MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites Hotel
1250 22nd Street, N.W.
Washington, D.C.

Friday, April 30, 1999
9:13 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
P. WILLIAM CURRERI, M.D.
ANNE B. JACKSON
PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
D. TED LEWERS, M.D.
HUGH W. LONG, Ph.D.
WILLIAM A. MacBAIN
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA

AGENDA PAGE

P R O C E E D I N G S

DR. WILENSKY: Good morning everyone. We had, I think, a very good discussion yesterday on a variety of issues and, to my mind at least, our best full discussion on graduate medical education issues. I'm pleased that, although we have a lot of areas regarding graduate medical education that we have not yet resolved, I think the discussion yesterday was both substantive and seeming to move in a consistent direction. So I look forward to continuing to look at these issues.

This morning's session is going to start out on access to home health care services. Louisa and Scott?

MS. BUATTI: As you know, the BBA required that HCFA implement a new payment system for home health agencies as a prospective payment system is being developed. The interim system makes substantial changes to the way home health care agencies are paid under Medicare, mainly by imposing an aggregate, per beneficiary limit.

Concerned that the interim payment system limits were affecting agencies' ability to provide care to Medicare beneficiaries, the Congress loosened these payment limits somewhat and directed MedPAC to examine access to care. In

doing so, we looked at the number of agencies providing services to Medicare beneficiaries, agencies responses to the IPS, and beneficiary reports of access problems.

In interpreting the results of these studies, it's important to consider two things. First, there were a number of other policies that were implemented at the same time as the interim payment system that may be influencing the provision of home care services. These include some anti-fraud and abuse initiatives, the removal of venipuncture as a qualifying service for home health care, and increased Medicare claims review and a new sequential billing policy.

The second point to keep in mind is because the current Medicare benefit for home health services is ill-defined, it's difficult to assess whether the changes that we have observed are desirable or not.

In looking at access to care, our methods are the following: We surveyed the Medicare certified home health agencies to learn more about how their practices have changed since the implementation of the IPS. We also examined Medicare claims data. And through a contractor, we convened a panel of individuals who are familiar with

Medicare beneficiaries' concerns about access to care.

Now I will hand it over to Scott to discuss the survey and claims analysis.

MR. HARRISON: We commissioned Abt Associates to conduct a random national survey of home health providers. They completed over 1,000 interviews. The sample is derived from HCFA's OSCAR file as of the end of 1998. The survey was done in March.

We got over 1,000 completed interviews. Two of the things to notice here, though, are the last two numbers, particularly the 149 sites. They were called and they said we no longer provide home health care. I'm not sure what they're doing now, but we've got 10 percent of the sample that says that they're no longer open. You have another 5 percent or so that had non-working numbers. The message came back it was disconnected, no forwarding number and they were not found in local directories or in a national directory. So we kind of thing they're not there. So they really closed for business and didn't bother to tell anybody.

So you could have a reduction of say 15 percent that may have occurred sometime during '98. It could be

that the OSCAR file lagged and we didn't know that they were really closed earlier, but there is this problem.

We asked the agencies whether they were accepting new home health patients and virtually all of them said yes, they were. Then we asked more specifically whether they were accepting Medicare fee-for-service patients. 73 percent said they were accepting all new Medicare patients. 26 percent said they were accepting some, and 1 percent said they weren't accepting any new Medicare patients. We asked about their Medicaid case load and 56 percent of the agencies said that their case load had decreased.

While the focus of the survey was on the interim payment system, not all of the questions would be interpreted as having been affected only by the interim payment system. In particular, here you have reasons why. For instance, the venipuncture was no longer a qualifying service so you might see a decrease in case load. Also, about three-fourths of the agencies said that they found physician reluctance to refer, probably stemming from the fraud and abuse new guidelines that had come out.

We then tried to narrow the focus to IPS and asked

if there were patients who they would have previously admitted under Medicare but they no longer admit due to IPS. Almost 40 percent said that they no longer admit some patients. However, you'll notice back earlier, only about 30 percent said that they didn't accept all Medicare patients. So you have a little disconnect there. Also, 30 percent of the agencies said that they had discharged patients due to IPS.

We took a look at both of them. When you combine the two questions, 47 percent said either they discharged or they no longer admitted or both. So you had about half the agencies who said that they've changed their admissions practices.

We then asked what types of patients that they were no longer admitting or discharging earlier. Patients who needed long-term services were the number one reason. You see venipuncture comes up with number two, and that's probably a good thing, that they've dropped patients who were no longer qualified.

Long-term and chronically, we looked at combining them. 24 percent, if you put them together -- you could have multiple mentions here. So you could mention long-term

and chronic. If you mentioned either one, that was 24 percent of the sample. Another way of interpreting this is only about half the agencies answered these questions because they said they no longer admitted or discharged. So of the ones that said that they changed their patterns, about half of them said that they either didn't accept long-term or chronic patients or had changed their admission practices relative to those types of patients.

We then asked if they weren't getting care from your agency, where were they getting care from. The number one answer was that they weren't receiving any care and the other most popular answer was nursing facilities and nursing homes. We have not been able to get any reports of whether nursing home admissions have fallen off in response to this.

We then moved to patients that they were admitting. 71 percent reported that they had decreased the number of visits they provided to each patient, on average.

We also checked to see if they had changed their mix of services and 45 percent said they had. And we asked how they had. The two largest responses were that they had decreased the number of aide visits and decreased the number of skilled nursing visits. There's also some reduction in

rehab according to this.

These were, of course, self reported agency interviews. We tried to compare these with utilization data. We've had problems with the utilization data. We got data from the first six months of calendar '98 and they looked very strange. We cut back to the first three months. They looked a little more reasonable but HCFA really thinks that there's some processing problems and isn't comfortable with having the numbers out.

Our preliminary look, though, showed that there was a reduction of say a fourth in the number of visits provided over the past year that admissions were down and from what we could tell from the mix of services it did look like the relative frequency of the aide visits were down.

So there was some corroboration. I recently called the intermediaries because the data problem was in the link between the intermediaries and HCFA. I called the intermediaries and the intermediaries thought that the preliminary numbers we had were definitely in the range of possibility.

DR. WILENSKY: Are these numbers going to be corrected at any point? Or will we just have to wait until

another quarter is available to get --

MR. HARRISON: HCFA has said that they plan to have all of the intermediaries resubmit bills in May or June.

DR. WILENSKY: How long would it take then to see that data?

MR. HARRISON: My guess is towards the end of the summer.

MR. MacBAIN: Just a question on the number of visits per admission. Is that adjusted for the change in case mix resulting from the lower frequency of admissions for long-term and chronic?

MR. HARRISON: No.

MR. MacBAIN: So that could be the sole explanation for the change in the average visits?

MR. HARRISON: Yes.

MS. BUATTI: MedPAC contracted with Abt Associates to try to learn more about the nature of beneficiary access problems. Abt convened a panel of individuals familiar with beneficiaries who use home health care and also home health care needs.

We hoped to learn whether or not the payment

policy changes have affected beneficiaries' access to home health care and also to get a sense of what happens to beneficiaries when they are unable to access Medicare home health services.

The panel met on March 22nd and included 14 individuals with firsthand experience with beneficiaries who had reported difficulty obtaining Medicare home health services. The panelists represented a wide range of professional backgrounds, medicine, social work, nursing, legal aid, advocacy, and Medicaid operations.

Because home health use has varied geographically, we also attempted to select panelists who came from a wide range of geographic areas. The panelists represented 12 states and the District of Columbia. About half of the members of the group were familiar with beneficiaries who were having access problems in rural areas.

A few themes emerged from the panel's discussion. First, the panelists stressed that the home health environment has changed considerably since the IPS was implemented. Home health agencies are becoming much more conservative in their practices.

According to the panel, before the IPS was

implemented, beneficiaries had little difficulty obtaining home health services that they believed they were entitled to under the benefit. Now the panelists believe that beneficiaries are experiencing much more difficulty getting this care.

The panel described situations where beneficiaries were refused admissions to home health agencies and other situations where beneficiaries had been discharged abruptly. According to the panelists, agencies are able to avoid taking new patients by asking questions of hospital discharge planners and physicians before they accept them. This way they're able to make some sort of judgment about the costliness of the care that they'd be taking on.

The panelists also reported that the agencies discharged expensive patients abruptly by telling beneficiaries in some cases that their Medicare benefit had run out or that they had reached their cap. According to the panelists, the patients most likely affected by these sorts of practices are again the long-term patients and patients with chronic care needs.

According to the panel, these changes in agency behavior have resulted in a shifting to other payers and

also an increased burden on family members. I would note that with respect to the cost shifting to other payers, the survey did not suggest that that was happening very frequently. It's also possible, however, that the agencies might not be in the best position to know what happens to patients that they turn away.

When beneficiaries experience access problems, the panel indicated that the beneficiaries are powerless to appeal the decisions of the home health agencies. This stems from the fact that the current Medicare fee-for-service appeals process does not address the situation that some beneficiaries are facing. That is being denied admission to the agency. The current appeal process can be initiated only after a bill has been submitted to Medicare.

Another area of concern of the panelists was that even when beneficiaries are under the care of an agency and the services that are being provided are reduced or are discontinued, Medicare beneficiaries are often not aware that they have rights to appeal the decision and if they are aware they often don't know how to go about this.

That concludes the findings from the panel. I'd kind of like to move to the draft recommendations unless

there are any questions beforehand.

DR. WILENSKY: Are there any --

DR. LAVE: Is it appropriate to make some comments on the text before we move to the recommendations?

DR. WILENSKY: Sure.

DR. LAVE: These are going to be somewhat similar to some of the comments that I sent out earlier. First of all, let me congratulate you. I'm really impressed with the amount of material that you actually managed to get done in such a short period of time. So I think this is really excellent. But my concern is that the draft chapter is really in an a historical context.

There is a little bit there about where we got where we were but I think that there should be more there about the problems that some of these systems were designed to put in place. For instance, you mention that there was an increase in growth but there also was the GAO report that suggested that about 20 percent of these visits were fraudulent.

When you put those two things together there really isn't a fair amount of information that suggested that the home health agency business had a lot of problems

associated with it, and none of that comes in here. So all that you have in here is that you sort of have this thing and people's access was being done.

DR. NEWHOUSE: It's actually consistent with the 10 percent of the agencies that no longer conducted home health and the 5 percent they couldn't find.

DR. LAVE: Right. So that's sort of the first point. And the second point is that HCFA had really only a very blunt set of policy instruments that it could use to try to target this. And then I think that would help.

The third thing is, with respect to the IPS, and I may have gotten this wrong but between 1994 and 1998 I think the average number of visits per enrollee increased substantially. So when you say that in 1994 that the costs were a lot higher in 1998 than they were in 1994, I think most of us would intuitively think you're talking about the costs per visit.

But the main thing that happened between 1994 and 1998 was that if, in fact, the average number of visits increased 50 percent that's really a huge impact. And somehow or other, this textual stuff doesn't come out to really kind of get to you that you had a real problem. You

had a very blunt set of instruments. HCFA did something that really the cost implications are really much more dramatic than it sounds because of the significant increase in the number of visits over this time period.

I think if we had all that there, then it's easier then to sort of thing about some of these recommendations and how to process them. That leads you to the idea that really -- I mean, first of all, I think we want to figure out why we have this benefit. I would describe that up front, that there are real problems articulating this benefit. We don't know what you're entitled to. We think you're entitled to everything and nobody knows.

So I think that would then, I think, set the stage much better for some of these recommendations and I think would allow us to take some of this stuff and put it in construct. To me, it leads to payment policy, the outlier policy kind of falls from this. So I think that would be helpful and can help with the recommendations later.

MR. SHEA: Just a specific to follow up on that. Your Table 10 shows numbers from '96, '97 and '98. I think it would be helpful to have an earlier year's numbers there, too. It shows that from '97 and '98 the total visits went

down 28 percent, average visits down 14 percent.

Those are big drops and they come against what the charts shows as a 3 percent, about 3 percent increase in visits from '96 to '97. It would be interesting to know what was the rate in earlier years.

DR. WILENSKY: You actually ought to start around 1990. That's where what this was put in place was responding to was the trends, and then we can make whatever judgments you want. But I think to give it some historical context.

MR. SHEA: Right. I think that would be helpful. I mean, this suggests a very big change, along with the 5 percent of the people who no longer exist, and the 10 percent. You know, it seems like something big happened here, but a little bit more data I think would be helpful.

DR. NEWHOUSE: Could we paraphrase that by saying if the sky is falling it started from a higher level?

[Laughter.]

DR. KEMPER: I really agree with what Judy said, and also, Louisa, you mentioned something about it's hard to know whether these are good or bad changes, in some sense. I guess some notion that some of these effects were intended

by Congress and then some of them, I'm sure, weren't and are undesirable. So it's kind of hard to make a judgment just from the trends.

I guess the other question I have is do you have any information on differential impacts across agencies, not only geographic but across agencies? Or at least a sense of that? Because I assume that there's some very big differences and perhaps some real inequities that have arisen across agencies, just depending on where they started and so on.

It seems like if you do have some information on that, that could be an unintended effect of great significance that would bear comment on. Do you have any information on that?

MR. HARRISON: We haven't gotten to the cross-analyses yet, but smaller agencies seem to be having problems, and agencies in the Texas, Oklahoma, Louisiana area, where they've been growing quickly, they've been having problems. There's more that can be gotten out of there, but those are the early two things that we've seen.

DR. KEMPER: There may not be time at this late hour to deal with it in a data sense but maybe just making

that point, that that's a big issue would be helpful.

DR. NEWHOUSE: That last comment, Scott, Louisa, you may want to have a table, if you can get it, that shows these '90 to '98 trends by state. We know that there was tremendous variation at the state level, so were the cuts disproportionately in the high states? Or were they kind of across the board? I guess there's a little bit of that here. The sense I have from some of the data I've seen, for example, is it cuts much bigger in Louisiana which was very high, than in Minnesota which was pretty low.

Playing off something Peter said, and trying to transition us toward the recommendations, maybe if we're going to have a recommendation that says monitor access, we should say what we mean by that? Or do we just mean what's kind of here, visit counts, which I think we all fumble around with trying to interpret? Or do we have something more in mind that we--something that's more normative? So we would say this is good or bad.

MS. ROSENBLATT: I just have a question about the numbers, given what we said about HCFA's concern with the first six months. If you look at a table like table 10, is that categorized by year based on service date or payment

date?

MR. HARRISON: It's billing date. But home health agencies typically bill in month-long periods.

MS. ROSENBLATT: But that sequential problem that was mentioned, is it possible that they're still a data problem in the first three months of '98 because of that?

MR. HARRISON: It's possible. It's not clear when the sequential billing policy started. We've heard different things. Some of them have said that it didn't start until May. Some of them said they may have started rolling them out early. We're not sure.

MS. ROSENBLATT: But HCFA felt comfortable with the first three months of data but no --

MR. HARRISON: No, they didn't. They just don't know.

DR. LAVE: One of the things that I would be curious about, against this chart, if we look at the difference between 1994, we look at the regions by the increase in the number of visits between 1997 and 1994, that's going to give you some idea about how much they're going to have to change their behavior in order to fall within the per beneficiary limit, I think.

That would give you some sort of idea about the kinds of pressures that were on there, since that might be a driving number. Because this is really--I think that's really probably very binding on past behavior on some of those particular agencies.

I think there is another question. In terms of looking at access, and I guess we're going to get there, there seem to be two different type of access issues. One issue is whether or not people are able to have -- whether or not, if people are recommended to get to home health services, whether or not they can eventually receive home health services. And it could be that it's hard to know whether or not the problem is a problem like the HMO problem which somehow or other is that I couldn't get to HMO A because it closed down but I had C, D, E and F there, and so I ended up being able to enroll.

So if I am at a place with multiple home health agencies, it could be very true that home health agency A may not take me, but home health agency B, C, D, and E may take me. So when you're looking at access, it seems to me you have to go to the patient and not look at what's happening at the facility level in order to make sense of

all of this.

MR. HARRISON: Our beneficiary panel did not seem to indicate that there were particular problems in finding an agency, just finding an agency that would accept them.

DR. LAVE: That sounds to me like it's hard to find an agency. Eventually they got accepted.

MR. HARRISON: No, not necessarily.

MR. MacBAIN: To go back to Joe's point. I think in monitoring access, there are two things going on and we need to look at both of them. Admitting practices concern me a lot more. I think that if we've got 60 percent of the surviving agencies saying that there are patients that they used to admit that they no longer admit, and a quarter of the surviving agencies are specifically focusing on people with chronic and long-term conditions, that may be a pronounced access problem, if it's real, if it's borne out by more data.

The length of stay of those who are admitted was an anticipated result. I think that was more likely what was the focus and I'd be more comfortable looking at the two issues separately.

MR. SHEA: I thought one thing that was striking

about this chapter was how hard it is to get information or reliable information analysis on what's really happening to beneficiaries. And I applaud the work that you did here in terms of the panel in trying to get some sense of that. But it just underscored, for me, the difficulty that we have throughout this of, you know, we wind up looking at surrogate measures because it's so hard to get at the real measures. Or maybe what would be the most important measures.

Here's a situation where there was a very big change in the numbers and yet we have no really good data on what happened to beneficiaries as a result. It just points up to me the need to try to think about this in terms of are there measures going forward that we could recommend some way to track these kind of developments? Not attacking this specific problem but -- so any suggestions that I think we could make in this context about that would be helpful in terms of the overall work that we need to do in the program.

DR. WILENSKY: Gerry, there's a real time issue.

MR. SHEA: That, too. But I think there's just a problem to figure ways to get reliable information.

DR. WILENSKY: I don't think that that's so much

the case. I think that the current survey will give us, at least from the patients' point of view, a good response as to whether or not access is an issue. In this case, I think there are two big problems that we're facing that we aren't likely to see resolved quickly.

One is that there's a sense that there was a data glitch because they changed who was funding home care as a result of BBA and there's some question about in the first six months whether they got it right. And so the common working file, which normally would show that, may be giving biased information. Presumably that's a problem that by the next quarter will be taken care of.

It strikes me the biggest problem we have in home care is one that we've identified in the past, which is we don't have good clinical indicators. What we know is that in the decade before this, which presumably Congress was responding to, double the number of people roughly received some service and for everyone who received any service they received roughly twice as many visits during that period.

The problem was it was hard to tell whether that was good or bad. People were a little dismayed. That seems like a little too much of a good thing. But they really

didn't -- I mean, it was just because that seemed like such a big number, as opposed to saying relative to their clinical problems.

So I think mostly what we're seeing is a real problem in getting real time information. That's for sure. And not knowing relative to what. We know it goes up or it goes down but we don't have a very good -- unlike a lot of what we were talking about yesterday where we kept using clinical indicators when we were talking about renal care, when we were talking about some of the other areas. The problem here is we don't know what they're supposed to be covered for because the coverage guidelines aren't very specific and we have very little in the way thus far of clinical indicators.

So we don't know whether getting more or less or fewer or more people is good or bad, in terms of their health care.

MR. SHEA: I was just making the point, besides the general observation, and I don't disagree with anything you said, Gail, I was just making the point that if there's anything here from this experience that we could recommend in terms of how to get reliable information faster, a phone

survey of agencies, or I don't know what your work might suggest, if anything here, that could be in addition, I think that would be very helpful. This is a situation that's caused a lot of public comment and obviously the people who need to make decisions, whether it's HCFA or Congress, need as much information and solid recommendations as they can.

DR. LEWERS: I think following up somewhat, Gail, on what you were discussing is obviously the changes are very interesting and striking and the question is what is and what is not acceptable and how to determine that. I think that's the point Gail is making.

You make a statement in here that the panelists felt that some of the -- I think that's the term you used -- some of the denials and some of the beneficiaries were unable to get medically necessary care. I noticed the panelists had three physicians, interestingly six attorneys. For a physician, I have to notice that. The one doctor is in an academic center so we don't know exactly whether and how much practice is there, although from the practice it appears that -- the other one has got to be. Anybody that lives on Happy Go Lucky Lane, he's got to be a nice guy and

in practice.

[Laughter.]

Do we have any feel at all what some is and what was the definition of medical necessity? You have 14 people who are on a panel and my concern is that people who should be getting this are not getting it. And I'm sure there are some, but I need to know what that relative number is.

MS. BUATTI: We didn't ask the panel to give us a sense of the magnitude of the problem but more of the nature. Again, we identified individuals to participate in the panel based on their knowledge of some problems, but we didn't think that they would be in a good position to tell us how serious the problem was.

With respect to the medical necessity issue, that was defined by the panelists within the scope of the Medicare benefit. But again, it was their notion of what they were entitled to.

DR. LEWERS: So you're saying within the benefit. So that means if the physician felt that the patient was sufficiently homebound and needed a venipuncture, even though that wasn't covered, that would not be declared as medical necessity? Because I can see physicians saying

that, that that's medically necessary even though it's not permitted.

MS. BUATTI: Actually, it's interesting you raised this point. One thing we learned from the panel was that there was some confusion about venipuncture as a qualifying service, in that apparently some beneficiaries --

DR. LAVE: Can you tell me what a venipuncture is?

DR. LEWERS: It's drawing blood, sticking a needle in a vein.

MS. BUATTI: Some patients who had other skilled needs, say regular nursing visits for another reason, in some instances were being denied the benefit from the agencies because they were interpreting the removal of the venipuncture as a qualifying service as a sort of disqualifying reason.

DR. LEWERS: I'd recommend that, perhaps in the text, we make a statement about the medical necessity element of it, and that it was left to the panel. Because I think this is a key element, and I think this is a core element to follow. I think that what we're concerned about is that we felt there were too many. Now did we get rid of the right ones or did we get rid of the wrong ones?

So I think that's the core of this whole thing and it's certainly something we need to follow. And in the recommendation that we continue to follow access, I would prefer that some language go in regarding medical necessity or some services of that nature. That's what we really need to track.

DR. NEWHOUSE: But do we know what's medically necessary?

DR. LEWERS: That's part of the problem. Obviously, that's one of the debates now, on what is medical necessity and how do you define it. But I think we have to have some parameter, at least, to follow. Whether we want to try and define it or not is another element.

DR. ROWE: Just two minor points. One is I think it would be, even though she doesn't join us until next month, we should show Carol Raphael this material and get her comments. I'm sure she'll be very helpful. You might give her a little of the background of how you did it.

DR. WILENSKY: Good idea.

DR. ROWE: The second is, while I accept the intrinsic argument, the central argument you hold, is that these changes were induced by the IPS. That's what you

state. It's kind of a post hoc ergo propter hoc argument. I think it is appropriate to have a paragraph in there that says there might be two other factors, secular factors, in the home care industry that could have influenced these changes, at least in part. Again, I accept the argument that this was very likely to be induced by IPS.

One is that in some markets home care agencies are finding work force problems. They have had very rapid growth, almost unrestrained growth. They're having difficulty, with a lot of turnover, and that some of them may not be continuing on their previous course. And so some of the reductions or the reductions in enrollments or whatever might be a function of what's going on in the local market. We could make a few phone calls and find that out.

It should just be in there if for no other reason to put it up and then discard it, but to show that we considered it.

The other alternative hypothesis is that, in fact, this is prospective regarding the PPS change. That is, if you were running a home care agency and you knew that there was going to be a PPS rather than a cost-based payment and you understand that it takes a while to remodel the behavior

of your agency independent of whether the interim payment system had been introduced, you might, six or eight months ahead of time, begin to change the mechanisms and the enrollment and the practices and policies in your organization so that you don't get caught with a lot on the table when PPS comes in.

Now it was originally schedule for October. I don't know when it was expected to actually be --

MS. BUATTI: One year later.

DR. ROWE: But I doubt whether that -- I think the reason against that is, in fact, most of the patients will have been gone. The metabolism is pretty high. But it takes a while to change behaviors of organizations and a good manager would start to think about that.

So I would just put those two things in a paragraph and say these are two other potential factors. We don't think they contribute a lot of the variants here. The timing is such that it really looks like it's the IPS but at least you give it a more robust --

DR. WILENSKY: I'm not sure -- I think those are two -- I'm not sure I would demean them as much.

DR. ROWE: I don't know how to discount them, but

I think we should just have them in there as potential factors. Whether or not that's true doesn't really matter. If we're concerned about beneficiary access, whether the problem is workforce or prospective for PPS or the IPS, our dependent variable is still beneficiary access. So we're still as concerned about the data. It wouldn't discount the findings, but some of the rationale.

DR. NEWHOUSE: I'd like to raise a fundamental question about quality control in this industry. Is there an analog to JCAHO accreditation?

DR. WILENSKY: Rather than the states certify and license.

DR. NEWHOUSE: But that's different.

DR. WILENSKY: JCAHO may be doing some accreditation of these. I don't know.

DR. NEWHOUSE: I guess I've been thinking about --

DR. WILENSKY: We'll find out.

DR. NEWHOUSE: I've been stumped for a long time about essentially accountability in this industry and how would we know what actually goes on? Now the MCBS that Gail brought up is helpful but a lot of the action here is going to be with the frail elderly, some of whom are going to be

demented. And I worry about how well that group is actually going to respond on the MCBS.

As best I can tell from talking to people in the industry, kind of the cutting edge of accountability is that when the agency person gets to the home she punches in a number to show she got there and then when she leaves she punches in a number to say that she's leaving, so that somebody can track that a body was actually out in this house for x minutes. But that, at least the last time I asked, was still a minority of agencies that even had that.

So this kind of goes back to Gerry's comment about the reliability of the information. We're used to, I think, institutional settings where things come off the chart, many people have looked at the chart, looked at the patient.

What actually happened beyond some person was there for a certain amount of time, and how we would eve know that, I'm stumped about this. But I would feel a little better, I think, if there were an accreditation type process that somebody went out and looked at the agency and actually what they were doing.

And I don't know if anybody shares it but the issue ultimately goes back to when we look at claims data do

we know even what we're looking at, beyond the fact of the visit? And even that, in some times we may not know.

MR. SHEA: I think the Joint Commission does have a program for this, I just don't think it's very widely used because it's not required.

DR. WILENSKY: The only requirement is the state licensure and it's a question, I believe, of whether or not the home care agencies wish to have as an additional indication.

DR. ROWE: No, when the Joint Commission comes to accredit or review the accreditation of a hospital, they send three teams. They send a team to do the main hospital. They send a separate team generally to do behavioral and mental health services, including inpatient site. And then they send a separate team that does a separate visit for home care. And they give you a separate score for home care.

And if you get a type I problem in your home care, that means that you cannot get accreditation with commendation, for instance. And they give you a score and based on their score of 100 being a -- so you get three scores. You get a hospital score, a site score, and a home

care score.

MR. SHEA: That would be a very small percentage of home health agencies.

DR. ROWE: That's right, but --

DR. NEWHOUSE: But I wonder if we need -- it's probably too late for June -- but if we need to be thinking about what kind of standards we think there ought to be. Maybe what we have we think is okay. I'm not comfortable with it personally, from what I know.

DR. WILENSKY: We clearly need to establish what exists. There's still some question, especially aside from the hospital-based.

DR. NEWHOUSE: Yes, the hospital-based, that's fine. So maybe something like that should be for all agencies that deal with Medicare.

DR. WILENSKY: But it still doesn't really resolve the other problem that you -- that says somebody is looking at the general process outcome in general that goes on within an agency, which may be more than exists now, at least in some states. It doesn't get at the issue that in other areas in which Medicare pays, that you usually have some more direct way to go back and look at what was going

on with the patient.

DR. ROWE: To audit it.

DR. WILENSKY: In both a financial and clinical audit.

DR. LAVE: But under the new OASIS, isn't that the right one? Isn't there some of that data which --

DR. NEWHOUSE: The question is, how would you know? I mean how would you know what the agency reports really happened?

DR. LAVE: I guess the issue is that you would do the same thing that you'd do in another place. You would audit some of this --

DR. NEWHOUSE: How? You have a record that a nurse has gone out to this person's house six months ago and says she did something, or a therapy visit was given. But for all we know, maybe the person was confused that day and the nurse went on her way and got recorded as a visit of so many minutes. How would you audit it?

I'm stumped. I just don't know what to do here.

MR. SHEA: I think the OASIS is designed to produce some information.

DR. LAVE: To give you clinical information.

DR. NEWHOUSE: But again, how do you know that it's accurate?

DR. LAVE: Does some of that clinical stuff change that much, if you go in and follow? I mean, if you do some real time you could go in -- the person is not going to become undemented in 24 hours.

DR. NEWHOUSE: No.

DR. WILENSKY: We'll wait until we get to our public --

DR. NEWHOUSE: Maybe I'm being too dire here.

DR. WILENSKY: We will both get more information and have it at least circulated, if not relevant for the June report, about what actually goes on. This is an issue I think we're not going to resolve at this point, but during the public comment period if someone wants to comment.

DR. CURRERI: I have really two questions. The first is we know from previous experience that 5 percent of the people getting home visits account for 50 percent of the cost with an average of 250 visits a year or so. That's in distinction to the 95 percent which account for the other 50 percent which have an average of something like 10 visits or something like that in a post-acute period.

So I see these as two different types of patients. We've talked about it before, and I think they have to be monitored separately. For instance, I would like to know whether the reduction are primarily in these people who had 250 visits a year, many of whom I would think probably didn't need that many home health care visits, maybe needed some housekeeping visits or something of that sort to aid them in jobs around the house.

But I think in any monitoring system -- or do we know which of these two groups, very distinct groups of patients, are seeing the cuts? I guess that's my first question.

MS. BUATTI: We don 't know for certain. But given that the patients, most of the patients who are among the most expensive are the patients with long episodes of care, it's likely that those patients are having their services reduced.

DR. LEWERS: Bill, on Table 4.23, 19 percent were long-term patients so whatever that means.

DR. CURRERI: Whatever that means, right. And there were some additional chronic patients which may be long-term, too. I think that that was perhaps an intended

thing. You know, we talked about the fact that maybe it would be good in these patients to have within a limit some copayment so that they would realize how much in the way of services they were using.

But I do think in any kind of future monitoring you need to separate those two types out and look at them separately.

The second thing I'd like to ask you, I don't know about the other commissioners but as you know this is a pretty hot topic around the country, and I get deluged with all kind of inquiries from home care people who clearly don't understand what the IPS is. This business of saying when they reach the cap they have to discharge them, which of course is not true, and they don't understand that there's an average and so forth.

How much of the problem has resulted because of simply lack of knowledge of what the IPS is? I mean, to me, this seems to be like a big problem.

DR. ROWE: Murray has had some experience with this, as well.

DR. ROSS: Actually it's a couple pieces. But again that is one of the issues here when you're trying to

assess what's going on, is are the agencies reacting to the law as it's written? Or are they acting to this misinterpretation of an aggregate average versus a person-specific cap?

I'd like to follow up on the other points I have.

DR. ROWE: That's very common, by the way. This is not the first time we've seen this syndrome. Many physicians will be discharging a patient and say you have to go home because Medicare says I can't keep you more than five days.

DR. WILENSKY: Exactly. I was going to say, for the DRGs that would --

DR. ROWE: They don't understand the difference between groups and individuals.

DR. WILENSKY: I have heard a number of both patients say their physician told them, and physicians say well, I have to discharge them because I've reached day five and it's like no, no, the government doesn't care now. The hospital probably cares, but the government is butting out. They've made the payment. That's no longer their concern.

DR. CURRERI: But did you ask this question in your survey, whether they knew what the law was or not?

MS. BUATTI: We did ask that question. Most agencies said that they were very familiar with how the payment system works. However, this just based on a handful of phone calls but there were several of -- not several. A handful of agencies called me to follow up on the survey because they didn't feel that the survey fully addressed all of their issues.

And during those conversations I gathered that they were not that well informed about how the system works and weren't able to figure out averages. And again, the panel suggested that they had had experiences with agencies who were also confused.

DR. KEMPER: I can sympathize with that, just trying to read an explanation of what the IPS is.

I guess there are two points. Just going back to Gail's earlier comment about when are these services needed and Joe's comments about the medical records, I think it's important that we not give the impression that there are no clinical reasons that these services are given and that services are just being doled out sort of willy-nilly.

I think nurse's make plans of care, there are needed services for different problems that come up, and

medical records are kept. I think we should recognize that all that clinical behavior is there. We just don't know much about it, nor is it translated into anything operational in terms of the program.

And so I would argue that that's an area where we ought to do more as a commission to try to understand that and come up with an approach to this that would help inform the discussion, go the next level on this eligibility issue. And on the information reporting issue.

DR. ROSS: I just wanted to follow up a little bit on Jack's comment. First, thanks for using a Latin phrase that I understood today. The post hoc ergo propter hoc, we're in fact trying to avoid that and I hope that's the message that's coming through from the chapter, that there was enactment of the IPS but it was also accompanied by a whole host of other changes that does make interpreting what we're observing now difficult to do and link it back specifically to the IPS.

But the second I think is Jack, you had said that while in a sense it doesn't matter because what we observe is access and it doesn't matter how we got here. I think I would characterize that a little bit differently because, in

fact, it does matter how we got here given that a lot of the policy proposals that are out there are the IPS has done all of this. Therefore we should repeal it.

We would like to know, in fact, was it the IPS or was it some other combination? If we repealed it, for example, what would happen then? Would it completely undo all this? All the other pieces suggest, by itself, no it wouldn't.

DR. ROWE: I think that's very helpful. Specifically, I think if we want to soften the language a little bit, given all the caveats with respect to this, on page nine you start a paragraph by saying we found that the IPS created a more conservative environment for home health agencies...and so it suggests that, in fact, we had found that there was this direct link. And it's language that I was -- I think what we might say is that based on these findings we feel it is highly likely, or something like that, that the -- that was what I was meaning.

MR. SHEA: I do think that the drafting took some pains to identify the other things that were going on and say, it was your point, Murray. It did come across, at least in my reading.

DR. KEMPER: That's true, but the force of the chapter is IPS causes it.

MS. JACKSON: I think there are two things that I wanted to know. First those agencies, they are supposed to know what their responsibilities are.

DR. WILENSKY: Of course.

MS. JACKSON: Then who oversees to know that they are not assuming their responsibilities that they should be assuming?

Secondly, it says that on table 4 that about 23 percent of the patients are not receiving care. Why aren't they receiving care?

MR. HARRISON: What was what the agency thought was happening. The question was okay, if you're not treating this patient, where do you think they're getting care? And they thought that they weren't getting any care.

DR. WILENSKY: But obviously, we don't know how well they know what's happening to the patients that they aren't accepting.

In regard to your first question, it's basically the state licensure process and also, for those that are hospital based or who choose accreditation through JCAHO and

others, they are the ones that are making sure that these records exist or that people are doing as they're supposed to do.

MR. SHEA: When you look for, or do some redrafting along the lines that Judy was suggesting at the very start of this discussion, I think it would be helpful to put in, just to put this in context, some numbers about the use of home health services in general over time. Because there's a suggestion that comes up, or it's easy to go to a point of there's something going on here that shouldn't be going on, there's bad use of the program and so forth. And I think we need to look at the growth in Medicare as against the overall growth, so we can see is there something different happening in the Medicare population? Or is this part of a general expansion of the use of home health services?

DR. WILENSKY: I think we ought to look at the recommendations.

DR. NEWHOUSE: A large part of home health, I think, is the Medicare population.

DR. WILENSKY: I think we should just take them as a block, since they fit on one page.

MS. BUATTI: The first is to establish a system for monitoring access. As Scott mentioned, currently we're unable to measure use over time because of the claims difficulty that's happening right now.

In addition to look at use, it would be useful for HCFA to examine patient characteristics to determine if the types of patients who are using home care is changing over time. This will also continue to be a concern as the PPS is implemented.

The commission made a similar recommendation in March regarding quality of care in all post-acute settings.

MS. ROSENBLATT: I strongly agree with the recommendation. I just want to tack on to the question I asked before about the data.

Can we monitor use by service date, looking at service date in retrospect? So is it possible to look at service dates in say the first three months of '97, but looking at payment dates, maybe for 12 months after the first three months of '97? So that to the extent that there were billing problems you catch it all.

It's what actuaries would call a run-out study. That might do away with some of the data problems. I'm not

saying do that for the June report, but I'm just saying in terms of future monitoring is there a way to do that?

MR. HARRISON: I think the problem is that it takes a while for the claims to come in, typically HCFA's guideline is that you want to wait six months after the last billing date to assume that all the bills are there.

So when you want to do something in real time it becomes a problem. And that's -- we didn't violate those guidelines in trying to look for data here. This was an even worse problem, but typically that's what they recommend.

MS. ROSENBLATT: But you're waiting six months past the billing date, and I'm suggesting you sort it by service use date. You're sorting it by billing date, right?

MR. HARRISON: Currently there aren't service use dates. In the future, I think that bills are supposed to be set up so that there are. This is a home health problem only. For other services they do usually have dates.

DR. NEWHOUSE: I may well be a minority, but the use of the word access here makes me uncomfortable because it implies that we have some standard for judging access. I would prefer that we say monitor use or use by type of

beneficiary. What we actually are going to do rather than use the term access.

DR. ROWE: What about barriers?

DR. WILENSKY: But we're not monitoring that, we're monitoring use.

DR. NEWHOUSE: One could imagine using the MCBS in a barrier sort of way, but I don't know that I'd use the term barrier. I think we ought to be specific about what we will and will not measure.

DR. ROWE: If we're monitoring at the beneficiary level, then we're monitoring access. If we're monitoring at the home health agency level, we might be identifying barriers.

DR. NEWHOUSE: Even at the beneficiary level, access to me implies that we would know when access is appropriate or good or something like that, and I don't think we really do know that.

DR. ROWE: I understand.

DR. NEWHOUSE: The other thing I'd note, that probably should be in the chapter somewhere, is the visit decline. We think, or at least I think, that there was some undetermined amount of basically phantom visits that were

total fraud in the system, and probably there still are some. So to the degree that some of this decline may actually be decline in visits that never occurred, and that fits the -- as we said early on, the agencies that became, in effect, no longer there.

DR. CURRERI: I'd like to put into this recommendation also what I said before, that we measure use by type of patient. We divide it into two or three different types of patients.

Because I think that there could be vast changes, depending on whether these are long-term patients or short-term patients.

MR. MacBAIN: Just one concern. If we're talking about use rather than access, it could imply that we're looking only at users of services and I've got a real concern about these long-term care patients, chronic patients, that may not even be getting into the agencies now.

MR. SHEA: I have the same reservation to Joe's comment or a similar one. I don't disagree with the point that you're making, Joe, at all but the bottom line here is access to services and do changes in the program adversely

affect access to services. And I'd rather err on the side of asking the right question, even if the answer is going to be imprecise, and acknowledge that in some way.

DR. LAVE: I guess as I listen to this discussion I'm unclear about what we want the Secretary to do. And maybe we may want to talk about this in a little more detail. If I look at this question that says the Secretary should establish a mechanism to monitor Medicare beneficiaries' access to home health services, there are clearly two things that we want the Secretary -- or are suggesting that the Secretary could do.

One of which is to analyze and examine the utilization data as reflected in the claims in a very systematic way. And that's relatively easy to think about how, in fact, one would do that. You would look at episodes of care. You would look at long-term care. You basically would do it the way that I think Medicare has been doing it. And I think that's straightforward.

The second issue is do we, in fact, want her to establish something that gets closer, I think, to Gerry's view of identifying -- there are these two groups of Medicare beneficiaries, one of which is sort of people who

are being discharged from hospitals into short-term home health services. Do we think there's a problem there?

And the other one is the acute care one. And if we want her to monitor those, then it seems to me we have to talk about a beneficiary level monitoring system? Is that what we have in mind? Do we want her to go beyond looking at the data in the MCBS?

I guess I'd like to have a sense of do we want her to go beyond what can be done using existing data sources? Because I think that we can all think about --

DR. NEWHOUSE: I think that that's the right question. That's where I am, in terms of saying what we mean by access.

DR. WILENSKY: I think that it may well be possible to look at, to make the distinction between acute care and chronic care users, with the existing data sets. To me the real question is do we want to have the parallel construction we were using yesterday, which is the Secretary should develop clinical indicators of appropriate use and monitor access to appropriate use? Because I remain very uncomfortable, I think that the abrupt or perceived abrupt change that we are hearing about -- we can't document it as

well because the data is screwed up -- but presumably at some point we will really know that there either was or wasn't as much change as we're hearing occurred in home health care visits.

But frankly, it's going to be like well, that's an interesting number.

We really don't have a way to make much sense of it, particularly following what was going on the decade before, which is explosive growth in use of services and the number of people being served, which we also didn't know whether that was a good thing or a bad thing.

DR. LAVE: We had a strong sense, though, that some of it wasn't a good thing. If we hadn't thought that some of it wasn't a good thing, we wouldn't have done --

DR. WILENSKY: Right. So it might be that we could have, parallel to what we had in many of yesterdays, and then talk about the extent that we think either OASIS is or isn't.

DR. LAVE: So can I suggest that we put number one -- wait. I think that four has to be one, because until we know what it is that we want people to get to -- I mean, conceptually we have to know where we're going. And then it

strikes me that there are a number of different levels of monitoring. But I think we have to really come to the conclusion whether, as a committee, we want to have a much more intensive monitoring system along Gail's line than can be done using the existing data sets.

DR. WILENSKY: Let me raise an issue with regard to four.

DR. ROWE: Can I respond to your question about the clinical, Gail? I agree with you, I think it's a good idea, and I think what we talked about doing in the end stage renal disease program is maybe a model.

But I'm a little concerned that in those patients we can be very specific and quantitative with respect to the need for dialysis as measured by their urea reduction ratio, their serum albumen, et cetera.

With respect to the home care patients, we're going to have something like a diagnosis of wound infection. And some wound infections get better in five days and some wound infections get better in 60 days. Or we're going to have a diagnosis like right middle cerebral artery stroke and some patients really recover quickly or restabilize, and they're not going to benefit from further therapy. And

other patients get better gradually over a period of time.

I think that the relationship between the diagnosis, which is all we're going to really have on a good day, and the illness is more variable in that case. And so I just want to add that, as I think it's not going to be as easy as we would like it to be because of these considerations.

DR. WILENSKY: And I accept that. This issue about establish clear eligibility and coverage rules is one where at least some members of Congress think that it is not a statutory issue, it's a regulatory issue. I think that there are really two different factors that are getting raised here.

To the extent that there is some question about what the Congress intended as the benefit, we can debate about whether we think it's a regulatory issue or a statutory issue or that there needs to be some clear agreement about what these are, so that if you have someone who is making claim to a benefit it's clear they either are or are not covered.

But in addition to that, I would put developing to the extent possible clinical indicators of services, and

then monitoring access in use to clinically appropriate services, acknowledging in the text that this not going to be the specificity that we have in some other areas.

DR. LEWERS: You're raising the point that I wanted to raise; two items. The first is number four. I'm not sure that we want in law coverage issues eligibility, at least as I read those, since they're apt to change from a clinical standpoint, improvement, et cetera. So I think that should be regulatory, not in law. So your point about what did you intend, that certainly is appropriate, but not the clinical guidelines per se shouldn't be there.

The second is, and Joe said he may be in the minority on access, I don't think he is. My concern that I voiced earlier about medical necessity. Joe, I know the problems of medical necessity and we don't need to debate that here, but in the fraud alert put out by the HHS IG, it says medical necessity or medically necessary care, and it defines it as that that is determined by the certification that the physician is required to sign.

I think some of what we're seeing may well be a drop off of some of those in physicians that are uneasy about signing those certs and the requirements in doing so.

But I agree, we either need to quality for -- and I don't like the term appropriate -- but since it is utilized in other areas, perhaps medical necessity is a term if we're going to leave access. But I agree with you, we ought to change and put utilization or some other factor.

DR. KEMPER: I agree with you, Gail, in terms of a strategy, an overall strategy on access. I also think there are some intermediate things that could be done between that, which is a long-term and intensive effort, and just monitoring number of users. That is to develop some patient level data and look at for a particular type of hospitalization what's happening to the number of people who are getting home health or other kinds of post-acute care, how long the stays are.

Not that that's definitive, but it at least --

DR. NEWHOUSE: Is this beneficiary-based information or from claims systems?

DR. KEMPER: I was thinking of a claims-based system where you look at the hospitalization and look at that immediate post-acute care --

DR. NEWHOUSE: But I can imagine we'd want some beneficiary stuff in there.

DR. ROSS: We've already initiated some work that will be headed down that direction.

DR. KEMPER: I meant to do that at the beneficiary level.

DR. NEWHOUSE: I understood that. What was the source of the -- I mean, I think we may well want some stuff that the source is the beneficiary.

DR. KEMPER: Yes, that's fine. I know that staff here have done it before.

DR. ROSS: And we're starting along that road for other purposes. We'll bring you some of that at the retreat.

DR. NEWHOUSE: Where did we wind up on four?

DR. WILENSKY: I think that we want to move that earlier. We want to make a distinction between eligibility of coverage in terms of what is there with regard to statutory clarity and regulatory clarity, and then the use of what that means for development of appropriate clinical indicators, and then the monitoring.

DR. NEWHOUSE: I was going to make a wording suggestion on four that we strike that are compatible with Medicare payment policy, since the Congress determines

Medicare payment policies.

DR. LONG: So removing that to be the Secretary will establish by regulation or the Congress...

DR. WILENSKY: There appears to be some disagreement of where the lack of clarity lies.

DR. ROSS: Let me make a couple of points there because of feedback we have received from a few different sources. One is the question of whose court the ball is in on this, whether it's the Administration or the Congress, to act next.

Second, whether it's possible for commissioners to be more expansive on what we mean by clear eligibility and coverage rules, because at the moment that's a pretty broad brush recommendation. If there are specific suggestions, either as examples or incorporated as a part of the recommendation, that would be helpful.

DR. KEMPER: I guess I would certainly, with Ted, want it to be regulatory and along the lines of what Gail was suggesting, to develop the clinical criteria for coverage of service and so on. That's a fairly nuts and bolts effort and that seems to me inherently regulatory.

The only reason, as I recall our prior discussion,

because I think this repeats an earlier recommendation, that the only reason we felt that Congress had to do something was because of the court cases that appealed to that. So I guess the way -- I don't know how to write the recommendation but Congress should do the minimal necessary to allow it to be a regulatory effort. I mean, that's the concept that I would think -- and I don't know what that is as a practical matter.

DR. LEWERS: I don't think we know whether there needs to be change in the law and whether they need to change -- I mean, certainly I don't read the law. But I do know that we do need a definition change and hopefully they're working on homebound. I mean, that's a terrible definition.

DR. WILENSKY: And one that does not appear to be much in use in a common sense of the term.

DR. LEWERS: I think the Secretary is working on that.

MS. BUATTI: Yes, she is.

DR. LEWERS: But those are the areas and so, I think if we can establish that there are hangups in the law, then we should request that Congress change that. If not,

it should be regulatory.

DR. WILENSKY: It sounds like we think primarily this is a regulatory issue.

DR. NEWHOUSE: Yes. But I agree with what was said about we need to say what we mean here. I think we should say the Secretary should look toward this long-term thing of what is clinically appropriate or necessary, or whatever we want to phrase it, but get on with that job. But that's got a very different flavor about it to me than eligibility and coverage guideline. Maybe we would want to cite the homebound definition and getting on with that.

DR. WILENSKY: But also indicate these are primarily, if not entirely, regulatory issues.

DR. KEMPER: Maybe at this point we need not repeat this recommendation but focus on the one of developing the clinical criteria for necessary care. I mean essentially replace it with that and focus on that at this point.

DR. NEWHOUSE: Really then that leads on to having done that, then we're in a position to really monitor access.

MR. SHEA: So essentially we're talking about

clarifying in the way that you first put out, Gail? Trying to develop clinical indicators?

DR. WILENSKY: And also to develop, through regulations, the definition of homebound. I mean, there are some issues that the Secretary has been directed to do that are also regulatory in nature.

DR. NEWHOUSE: Those are presumably short-term things.

DR. WILENSKY: Yes, those are short term. And long term or intermediate term to develop appropriate clinical indicators and then to monitor access in use of clinically appropriate services. So that we set up a several stage process.

Do you want to take the second and third?

MS. BUATTI: The second recommendation actually on the slide, I guess we're missing the word timely information to home health agencies.

DR. LEWERS: It's in the chapter.

MS. BUATTI: Right. This is in response to the confusion that was reported about the interim payment system and the fact that it was implemented quickly and that because of that the BBA gave HCFA several months in order to

develop the payment rates and then notify the providers how they were to be paid. And in many instances that was well into their fiscal years.

So this is just a recommendation that the Secretary improve the communications with the providers and is something to keep in mind as we move to a PPS.

DR. CURRERI: Do we really need this or has the horse already left the barn?

MS. BUATTI: Well, I think this is more directed towards the next payment system change.

DR. LEWERS: I was going to ask Bill the same thing. We shouldn't need this, but I think we do. The same thing with physicians. We're going to notify the home health agencies but the physicians who have to sign the certificates don't know the volume of the material and what they're really working with. We've asked the HHS IG, in their distributions, to make it clear and make it available to the physician community. But we've got to do that through the carriers because there's different interpretation by different carriers.

There is no uniformity. And the Secretary has to deal with the educational process. That has not been done.

Now they're working at it, but it's still not adequate.

And so I think we do need it, and I think we need to expand it. I think it needs to be to the community and to the carriers, that there has to be uniformity within the carriers because that's the key element.

If, as a physician, I sign a cert and I say this is medically necessary, somebody down the road in a carrier says no, it's not, and the next thing I know I'm up for fraud. Well, I did everything. I saw the patient, I did the physical, I've done everything, I've signed the form. And then I have a fraud alert because I've got a carrier who's interpreting it totally different.

So I think that is a very key element and I think we do need this. We need to keep pushing that point home.

MR. MacBAIN: I just want to underscore what Ted said. He's opened up a whole other area for inquiry in the context of home health, and I think the recommendation ought to specifically include the carriers as an audience.

But it gets me thinking, this is a little bit off this topic but maybe we'll want to address this issue of consistency of application of rules by the different fiscal intermediaries as another issue. I think it extends beyond

home health but it's pretty significant.

DR. LEWERS: It may need to be two recommendations, the one here on payment and then the other on the areas that Bill and I are talking about.

DR. WILENSKY: On the outlier policy?

MR. MacBAIN: On outliers, I can understand the need for that if we actually did have a per beneficiary cap or if we were already under a DRG or per episode system. With the average, do we have evidence that the average, the per beneficiary average is actually low enough that an outlier policy would alleviate some problems if the home health agencies were actually applying the rule as it's written?

MR. HARRISON: The way we were conceptualizing this is that there are certain patients who have expensive needs that seem to have trouble getting into the system. We thought that, in order to help those particular patients, we might want to have an outlier system such that the agency would be able to accept the patients without a huge financial risk.

DR. NEWHOUSE: You should say what you mean. What you mean, I think, is that they can exempt x percent of

their patients from the beneficiary limit.

MR. HARRISON: That's the way we were thinking of constructing it.

MR. MacBAIN: My question was, if the agencies come to understand what the payment rules really are under the interim payment system, is this still needed? Or how many agencies are likely to see themselves bumped up over the average because of some outliers.

And a related question, this gets back to what Jack was saying, if all we've got to work from is a diagnosis, how do we know if somebody's really an outlier? How do we know if somebody with wound care really needs to go for a year or a year-and-a-half versus a week? Is this something that HCFA could even administer?

DR. LAVE: Couldn't you do this kind of identify an outlier ex poste instead of ex ante? How do you like my Latin?

It does seem to me that -- I mean, that's why I would like to have some sense for what the per beneficiary limits are, because they really -- I think they really would mean that on average they would have to bring a lot of them down. And I can understand why people would be actually

rather fearful to bring somebody in who you thought might have a 200-day visit.

There may be some operational issues, but I think that by putting it this way, that you are drawing attention to a problem and wondering whether or not, in fact, you can do something innovative with the payment system to ameliorate that.

Now the problem that I have is that the IPS is supposed to be quite short and by the time we would develop this theoretically we're going to have a PPS system in place unless we thought that the PPS system is going to take a longer time to get here, which some of us do.

DR. NEWHOUSE: Some of us do.

DR. ROWE: I think from the clinical point of view it would be possible to do what you're staying. To paraphrase what you're saying, I think you could identify people post hoc rather than a priori, is the way I would put it.

I would say that the benefit of doing it that way is that if you try to do it up front you might say if you have a wound and you are diabetic as comorbidity, that's another diagnosis, then you are in a subpopulation that's

likely to be an outlier and have a non-healing wound.

On the other hand, a lot of diabetics with wounds have their wounds heal. So it would be better to do it after the fact, if you will, and take those people who appear to be outliers statistically or quantitatively and say all right, do they have the comorbidities? And if they don't, then what else is going on? Something like that. That would be a way to do it.

DR. NEWHOUSE: Bill, I think the answer to your question is the general economic principle that the system delivers what you pay for and its corollary that the system doesn't deliver what you don't pay for.

What we have, in effect, is that we've set up a system that the agency takes a loss on the heavy user. And the exemption is -- I assume we would then just revert to a per-visit payment for these. That would not be the case for some percentage of users.

This, I think, would also have the additional benefit that, as Jack said yesterday, in any kind of rate system there's a numerator and a denominator and the current system has the incentive to put in artificially light users. In fact, I don't quite understand why more of this hasn't

happened, where you send a nurse out to check of the person on discharge is taking their meds and if there's any side effects and so forth and so on. They would be homebound for some period after their procedure in the hospital. And you could justify, presumably, a visit or two.

And that would sure have a big effect on your average if you were averaging them with people that were getting 300 visits.

DR. KEMPER: But there's also a per-visit limit, a cost per-visit limit.

DR. NEWHOUSE: Okay, I could send the nurse out and be perfectly routine. I don't see that that should trouble me.

DR. KEMPER: Do a real cheap visit?

DR. NEWHOUSE: Or just do a regular nurse visit. That doesn't seem to have happened. The agencies are saying -- and in part, I suppose because if it's -- well, in any event, the outlier system takes away that kind of incentive to game this in that way.

DR. CURRERI: I don't think physicians are going to sign for that kind of home visit.

DR. ROWE: It may be as efficient as you think,

because as a non-economist -- as somebody who sort of like actually runs something --

DR. NEWHOUSE: Is that like the New York City Marathon that you ran?

DR. ROWE: I mean, you have to enroll the patient, you have to fill out all the forms, you have to get them eligible, you have to deal with the doctor, all this. It's a long run for a short sty, for two routine visits. It makes much more sense to use your infrastructure to enroll patients who are going to be around for -- it may not pay as well.

DR. NEWHOUSE: It hasn't happened, so I can't quarrel with this explanation, but I still think an outlier policy of the kind Scott is suggesting, I don't know what the right percentage is and we should presumably do some modeling on that before we push it too hard.

MR. MacBAIN: Joe, I think you're right, you get what you pay for. If you pay for outliers, you get outliers. And one of the big concerns we have is these people who use 250 visits a year. Those are outliers.

DR. NEWHOUSE: Absolutely, and I think that was how we got to the per beneficiary limit, but that's a pretty

crude or blunt instrument to deal with. Some of these people may well should be getting 300 visits.

DR. CURRERI: My concern is I think we need some data before we recommend anything. I think we have to know how many of these nursing homes are actually exceeding their average cost per beneficiary. And then there's also some cost offsets because they have other patients that are not in the Medicare system which they get paid more for.

I don't know how we establish what the right percentage of patients would be in an outlier system. I agree with Joe, that when you establish an outlier system, they'll find outliers, whether they're medically necessary or not.

MR. SHEA: I agree that we don't have the data we'd like to have to try to address the situation, but I also think people would appreciate some recommendation, if we're willing to make one. This seems, to me, a fairly sensible one.

DR. NEWHOUSE: I would say this is a little bit of a safety valve on an otherwise fairly blunt system.

MR. MacBAIN: In that case at least we ought to call it an exemption rather than an outlier system, because

otherwise it won't work.

DR. KEMPER: Definitely outlier. I would argue it should be small, a small safety valve. And I think one reason I support this is the cost of an error hopefully isn't very great because it's an interim system.

DR. NEWHOUSE: I hope you're not holding your breath.

DR. KEMPER: I'm not. But I wouldn't want this to be automatically assumed to be part of the prospective payment system and I think we should say something about that being a separate issue that ought to be addressed separately.

DR. ROSS: Could we address that point, the notion of being able to implement an outlier policy -- an exceptions policy, there's an issue of whether that could be happen in this year, with PPS scheduled for 16 months from now.

DR. NEWHOUSE: Would this require statutory change?

DR. LAVE: Yes. I would imagine.

DR. ROSS: I think, given what's involved with IPS, but there's also just the HCFA feasibility issue

between now and then.

DR. WILENSKY: Can we temper it to say, depending on the time or if possible to establish an exceptions policy for very expensive patients to put in the text that the feasibility of this will depend on how long we're in the interim process. And that, in fact, if it stays within the existing time frame of October of 2000? It probably won't be feasible, if there is any extension on that date, it would be desirable.

DR. CURRERI: Would you agree to say that this should be a small percentage of patients?

DR. WILENSKY: That's something we can put in the text, that we anticipate that this applies to a small number of patients.

DR. NEWHOUSE: I think we have to say it would or we totally remove the limit.

DR. WILENSKY: But I do agree with the notion that, practically speaking, if the current schedule remains in effect it is unlikely this could be put into effect in a timely way.

DR. ROWE: Can I recommend you change the wording in the fourth recommendation? It might be taken wrong by

HCFA for us to tell them to establish clear eligibility rules. They might think we're telling them their current ones are not clear.

DR. WILENSKY: That was with regard to the discussion we had earlier. It's going to go up to the front.

DR. ROWE: We just shouldn't use that term, clear.

MS. BUATTI: We won't use that term.

DR. NEWHOUSE: Clearer?

[Simultaneous discussion.]

DR. CURRERI: Is there a word missing in this fifth recommendation?

DR. ROWE: They should clarify.

DR. LAVE: And what the appeals process --

MS. BUATTI: Let me turn to the text.

DR. CURRERI: I didn't know whether it should be regarding this Medicare benefit or...

DR. NEWHOUSE: There's clearly a wording problem.

DR. CURRERI: It seems like something should come after rights and this Medicare benefit.

MS. BUATTI: Yes, right.

DR. WILENSKY: Thank you.

We're going to ask for public comment.

DR. LAVE: I do have a question.

[Laughter.]

DR. LAVE: I'm curious about why we want to have the second part here. We don't do this for physician services. We don't do this for ESRD. I mean, basically why would we want to have a separate mechanism for telling people about their rights to a home health benefit when we don't do it for any of the other benefits that they have?

It strikes me as if, in fact, it makes sense to have an appeals process. But why do we really want the Secretary to put a whole new system in place to inform beneficiaries about something?

MS. BUATTI: I think my wording wasn't very clear. Informing beneficiaries had more to do with informing of their right to appeal the denial of services.

DR. LAVE: Okay. That makes sense.

DR. WILENSKY: Thank you. Are there public comments on this section?

MR. CALLEN: Mark Callen, Health Care Association of New York State.

One of the comments that I have is related to the

background section. I believe this is important because, as I've heard the discussion today, there's been a lot of discussion about the patients that have 200 or more visits, and that the payment system was intended to curtail those very lengthy visits that have increased the cost of the home care benefit.

One of the problems that we have with the IPS is that, as initially implemented, the per beneficiary limit was based 75 percent on the agency-specific cost in the base year and 25 percent on the regional average. In New York State, and generally in most of the Northeast, the average number of visits per beneficiary are substantially lower than the national average.

And we have agencies --

DR. NEWHOUSE: I thought this was the regional average?

MR. CALLEN: No, 75 percent agency-specific and 25 percent regional.

DR. NEWHOUSE: Right, but not national.

DR. ROWE: The national doesn't matter.

MR. CALLEN: It matters from this point of view, that in areas of the country where the average number of

visits was at the level of 100, whereas in New York it's in the neighborhood of 50 to 60, what you end up with is a per beneficiary limit that is substantially higher. And we have agencies in New York who, because of the nature of the types of patients they treated in the base year, they might have had actually an average of 30 to 40 visits per patient, and they have grown to 50 to 60, substantially below the national average yet their per beneficiary limit is based on that base year.

Therefore, when you talk about solving the problem of cases that go over 200 visits, we have agencies who have problems in having 50 or 60 or 70 visits because it takes them over their per beneficiary limit.

So I commend you on the concept of the outlier concept or the exceptions concept based on the agency's average type of visit, because I think that that's essential and I think it will be very, very helpful in the short-term.

And secondly, I also want to point out one last thing about I guess the attitude of the providers who were hit very badly by this IPS system and, in anticipation of a PPS system which they don't know whether it's going to happen, and there's an additional 15 percent cut in the

total dollars in the pool for payments, and finally because of the problem associated with the information not getting to them in 1998 as to what their per beneficiary limit is, they're faced with a huge payback this year to Medicare for an overpayment amount.

So faced with the overpayment amount, faced with the inability to cut back on the visits sufficiently, and faced with a 15 percent cut and no certainty of what the PPS is going to look like, I believe we have a much more urgent situation with respect to providers in areas where they have been established and have gone through certificate of need process to get their license, and they are going to go out of business before we ever get to PPS.

DR. WILENSKY: Any other comments?

MS. SANTER: My name is Patty Santer, just a citizen of Arlington County and I do volunteer work in this issue area.

Two issues I guess I'd bring up. I think the historical nature you're pointing out is interesting and there are some factors I've seen at work in Northern Virginia that may play out in other parts of the country, too. That's the increase in growth of the assisted living

facilities and the impact it has had on the nursing homes and what type of patients the nursing homes are starting to want and see more of, more of the rehab type.

We've noticed a high turnover rate of people in the nursing homes. They're less wanting the long-term care patients, more wanting those short rehab patients, which is taking business from the home health agencies, too.

So when you're looking at the use patterns, it may be interesting to also consider those variables and how they may be impacting where people are getting care. It may not only be home health agency A, B or C. It may also be that nursing home rehab that's offering different services.

A second factor that I would raise is when I was working with a couple of groups in Northern Virginia on the OASIS instrument, and we're working on it from an issue of linguistic and cultural competence, we found it interesting that the OASIS tool, 16 pages of questions which nurses are supposed to specifically ask the question as it is stated on the form and receive a response back from an individual. And if you've ever gone on a home health -- I've been on two or three visits where we've done a sample of the OASIS instrument. There are a couple of other instruments that

the state uses. It's very hard to get a direct answer back.

One question it never asked was the language of origin. We're starting to see in more areas more individuals who don't speak English. And how home health services approach this language issue and how they're supposed to effectively evaluate with the OASIS tool those questions, asking specifically and receiving answers back makes it very difficult. And those are actually some patients that are starting to see their access limited because they don't want to take care of them. They're harder. They're more complicated to deal with. And they're usually more costly because they don't have insurance and issues have boiled that have not been taken care of.

So just a couple of factors that may be interesting.

MR. SHEA: Just on that point, I just want to clarify. Murray, when you were referring to some work that's in progress, was some of it addressed to the characteristics of the hard to serve or patients who get turned away?

DR. ROSS: No, I was referring more to trying to trying to link together the hospital stay and subsequent use

from the claims data.

MR. SHEA: Because I thought at one point in the text where that was referred to, the question naturally comes up why? And I know some of the answers from the agencies address that. But to the extent that we could fill that in, I think it is important, along the lines that our speaker just referred to.

There are certain groups of beneficiaries harder to serve and therefore easier to sort of kick out of the program, if you will, or for agencies to just say we don't want to deal with this kind of thing. I'm not asking for a specific answer. I just think it's something we need to look into.

MR. SOKOLO: My name is Eric Sokolo. I'm with the National Association for Home Care.

My question is you're looking at claims data from the first three months of '98. Yet, as one of the speakers just noted, agencies weren't notified of their PBL limits until April of '98. So how much IPS data are we really looking at, when we are comparing the claims data to the impact of IPS on beneficiary access.

DR. WILENSKY: As we are able to look at later

data, we will do so, but we appreciate the comment.

MR. SOKOLO: I hope that that's reflected in the report as well, that this first three months of '98 really does not include the IPS rates that home health agencies are operating under.

DR. WILENSKY: We'll make sure that it's in the text.

MR. SOKOLO: I appreciate that.

DR. WILENSKY: I want to pause for a minute before we go on, to revisit some of the recommendations yesterday. As we know on the commission, among the commissioners, but as people in the audience may not be aware of, two of the commissioners who have been long-time supporters of the commission are rotating off. We will have three of the commissioners whose terms expire this year be reappointed to serve one, two, and three year periods, and we have two new commissioners who will be joining us effective tomorrow to take the commission number up to 17, which is now our full staff.

But I wanted to just take a minute and to publicly acknowledge and to provide these two commissioners with a plaque indicating our appreciation for all of their efforts

and time spent.

Anne Jackson, who has been with us for a number of years, both Anne and Bill Curreri being PPRC alumni, that we have really appreciated your very faithful support of the work, your attendance at meetings.

Bill Curreri, for time over a long number of years and meetings attended. We really appreciate the efforts that you have made and I think the public has been very well served and the Congress, as well, by your willingness to participate and to offer your insights.

I will personally miss both of you. I know many of the other commissioners have mentioned to me also the fact they will miss your participation in these meetings. And I just wanted to take a minute to publicly acknowledge and to give you these plaques. We were going to do so yesterday but our day got very full and very long. So I wanted, before we went into our next session on recommendations, to publicly acknowledge that.

[Applause.]

DR. WILENSKY: Applause well deserved. Thank you.

We have two areas that we're going to revisit this morning. The first has to do with the frail elderly. We

have distributed draft recommendations from chapter five. Sarah has attempted to go back and look at the suggestions we made, and Tim as well, that we need to have people look and make sure they are comfortable now with these revisions.

Sarah and Tim, do you want to just highlight where you want people to make sure they look?

MR. GREENE: First we reordered the risk adjustment recommendations, put the more substantive ones up front. Second, we added a recommendation on partial capitation, so we now have four recommendations rather than three. And finally, we added a reference to at least one year in what is now the fourth recommendation.

DR. ROWE: Gail, are all these programs, I think they're limited to older persons. But are PACE, EverCare, SHMO, the five million disabled Medicare beneficiaries or those in end-stage renal disease who are Medicare beneficiaries, are they eligible for these programs?

MS. THOMAS: Under SHMO-II, disabled people can enroll. SHMO-I did not permit people under 65. PACE is limited by age to people who are 55 and older. So the 55 to 65 group could be in there. And Evercare is focused on nursing home. I'm not completely clear on --

DR. ROWE: I think in all these recommendations we should, instead of using the word elderly persons, we should say eligible beneficiaries or something like that, so that we don't unintentionally exclude --

DR. WILENSKY: Thank you.

DR. KEMPER: I may not remember the history, even though it's only 24 hours old, but on recommendation four you have the qualification that the commission recognizes that the Secretary's ability to use capitation methods for the frail elderly is constrained by implementation issues.

I think it's very important to recognize that, but I wonder if we could take it out of the recommendation? I don't know whether others would object to that. But my argument is that there are implementation problems, and there's absolutely not doubt about that, but there are avenues for approaching them. And it really undercuts the recommendation to put it in there.

MR. GREENE: Would you move that into the discussion?

DR. KEMPER: Absolutely. It's absolutely appropriate for the discussion and, time permitting, going into a little bit of depth about that beyond just a

sentence, but I'd just as soon have it out of there.

DR. LONG: With respect to recommendation four and in light of recommendation two, should not four include the possibility of setting capitation or partial capitation payments?

MS. THOMAS: How about simply payments?

DR. LONG: Okay.

DR. WILENSKY: Any other comments? Thank you.

Let's move to the section on financial liability.

MR. ZABINSKI: A common critique of previous drafts of this chapter was that it needed focus. So after thinking about it we decided to focus on three specific topics.

The first of these is examination of Medicare's effectiveness in preventing and reducing beneficiary out-of-pocket spending. The second is an examination of how cost-sharing and uncovered services contribute to high out-of-pocket spending by some beneficiaries. And a final is an examination of which populations are most affected by the cost-sharing and uncovered services.

What we found is that Medicare performs pretty well in preventing high out-of-pocket spending. It provides

nearly universal coverage for people age 65 and over. It is by far the largest source of payment for beneficiaries. For example, among the community based beneficiaries it pays about 62 percent of their total Medicare spending.

It tends to pay more of the total spending costs for high cost beneficiaries than what it does for low cost beneficiaries, indicating that the program tends to provide more assistance as more assistance is needed by beneficiaries.

And lastly, most beneficiaries avoid paying extremely large percentages of their incomes on medical care. About half of beneficiaries pay 13 percent or less and about two-thirds paid no more than 20 percent.

Now despite the successes of Medicare, we also found that there were three cost-sharing and uncovered services areas or issues that appeared to cause some beneficiaries problems in facing high out-of-pocket spending. One issue is the lack of an annual limit on out-of-pocket spending, especially for Part B services. This is especially important for beneficiaries with only Medicare coverage, as some of them have in excess of $15,000 in out-of-pocket spending in a single year.

A second issue is coverage policies for medical provider services and medical equipment and suppliers. For example, amongst the highest cost community based beneficiaries, this particular component of out-of-pocket spending generally drives their out-of-pocket spending.

Another issue on this line that we've found since you received the chapter is that within this component of medical provider services and medical equipment and suppliers, it is medical equipment and suppliers that is taking up the lion's share of that particular component.

The third issue is the lack of coverage for long-term care services. The average out-of-pocket spending for long-term care beneficiaries is generally much higher than what it is for the community-based beneficiaries despite a prevalence of Medicaid coverage for long-term beneficiaries. And it is this out-of-pocket spending on long-term care services that is driving their high out-of-pocket spending.

Now I turn things to Judy and she's going to talk about the remainder of the findings.

DR. WILENSKY: Let me just make a point with regard to this second overhead that was a presentation issue the way you've covered these three issues that were on the

second overhead.

It seems to me that we ought to distinguish, to the extent possible in charts and certainly in the text discussing them, the difference of the impact of long-term care from the other issues raised. The reason is that because Medicare was not intended as a long-term care support. Now it clearly has a lot of implications, that Medicare was not intended as a long-term support, and I have no problem saying when you include long-term care expenditures this is the impact of the present program on seniors.

But it strikes me it's really a different look to say Medicare was intended, with regard to acute care coverage, and here are the implications for beneficiaries. Not having a stop loss is a clear one. Some day I hope we can look at what it would cost and what it would mean if we had a stop loss, but that's within the intent of Medicare, here's how well it does and doesn't.

And then there's a second issue, that Medicare wasn't intended to be a long-term care provider of services. And that also has repercussions and here's what it looks like.

It's just this uneasiness of judging the effectiveness on a program on a criterion which it never chose to direct itself, although again I think it's a very legitimate issue. It's just that it ought to be cut, I think, a little differently.

DR. KEMPER: I think that's a very good point and strongly agree with it. So I think separating that issue out would be important.

There's an analog in the numbers that I at least found confusing. That is that you divide the population into people in the community and people at institutions, if I understood it correctly, and talk about the people in the community first, including discussion of long-term care expenses for people in the community, if I understood that.

MR. ZABINSKI: No.

DR. KEMPER: But it seems to me that -- and then later talking about the institutionalized population and talking about long-term care expenses. It seems to me I would like to see a separation between the acute care services that Medicare was intended to pay, but for the whole population, including the institutionalized, and then go to the issue of long-term care, again including both the

institutionalized and the community populations. So that you get a sense of the distribution overall.

I think it's very confusing to have these shifting populations back and forth as you go through the chapter. And it also doesn't give a clear picture of the overall distribution. Now that may not be possible in the time frame, but I did find it...

DR. WILENSKY: Right. Again, I don't know how long it will take to redo these numbers. I would be satisfied, obviously if you could redo them to reflect what I've suggested that would be better. If you can't, if you can just make it clear in the text that this is what Medicare was intended to cover and these are ramifications, here's an area it wasn't intended, it has major ramifications.

MR. SHEA: Just for historical purposes, wasn't there a lot of discussion about coverage for long-term care? I've heard people refer to the idea of a Part C.

DR. WILENSKY: I don't think that was really a part of the initial historical. We've had discussions of Part C in the last decade. I'm talking about more --

MR. SHEA: I thought it went back to --

DR. WILENSKY: It was not its initial intent.

MR. SHEA: I had a question about, while we're just on this, on the last slide -- you don't need to put it up -- do you intend to capture prescriptions in medical equipment and supplies?

MR. ZABINSKI: Prescriptions are not included in that category.

MR. SHEA: So you're not listing it as an issue?

MR. ZABINSKI: Prescriptions?

MR. SHEA: Yes.

MR. ZABINSKI: It's in the text, prescription drugs.

MR. SHEA: I was just surprised it wasn't on this list if you were making a list of issues.

MR. ZABINSKI: It didn't make my top four list.

MS. XANTHOPOULOS: In terms of the magnitude, the out-of-pocket spending on prescriptions, it wasn't as large as some of the other categories in terms of evaluating the financial burden to a beneficiary, although most beneficiaries have substantial amounts.

DR. NEWHOUSE: But usefulness of information on prescription coverage would be very helpful in the current

debate.

MR. SHEA: It's certainly identified among the beneficiaries as being a huge deal.

DR. LAVE: I'm surprised that medical equipment and supplies is bigger than the prescription drugs.

MS. ROSENBLATT: That was going to be one of my comments. The top of page eight really sort of makes light of the prescription drug problem. I was surprised at that so...

DR. ROWE: Were these data collected prior to the flurry of articles and recent debate with respect to prescription drug benefit, vis-a-vis the Bipartisan Commission? That may be part of the dissonance between our current view and the issue and what's reflected in these data.

MR. ZABINSKI: Yes, these data are from the 1995 MCBS, so yes, it was prior to that.

DR. NEWHOUSE: I guess the other issue I'll bring up now is I was troubled by the lack of confidence intervals on all of these numbers. Can you give me some sense of what like the $300 prescription drug number, what a two standard error confidence interval will be on that number?

MR. ZABINSKI: I can't off the cuff but it's available. I mean, I have the information.

DR. NEWHOUSE: Have you looked at it and is this a pretty small number? What's the n in the current beneficiary survey that you're looking at?

MR. ZABINSKI: About 12,000 and for the community based sample we used it was about 9,900.

DR. NEWHOUSE: These are just raw means?

MR. ZABINSKI: These are weighted means.

DR. NEWHOUSE: So some outliers could be swinging things around, or lack of them. I guess in several of these tables it may be helpful to present some error bars.

MS. XANTHOPOULOS: One of the things that we're planning to do in our continuing work is to look at the issue of the outliers because there are -- I think that's something that hasn't been done thoroughly because I've come across certain records that, to me, don't seem to make sense. We've talked to HCFA and they say they're real people and they're real numbers.

We have some concerns about those. So that's part of what we're planning to do.

DR. NEWHOUSE: So what are you going to do?

MS. XANTHOPOULOS: That's a good question.

DR. ROSS: I just want to make a point too, because when people are looking at the drug numbers in here, remember that this is out-of-pocket spending. So what you are not picking up is --

MS. XANTHOPOULOS: Medigap.

DR. ROSS: The reason why people want to get the gap plans is to get their drugs covered. That's imbedded in their payments for supplemental insurance.

MR. SHEA: And this paragraph on page 8 makes the point that that results in higher costs. I just think that the prescription drug issue, as Alice was saying at the beginning of this discussion, needs a little bit more attention here.

DR. WILENSKY: There certainly needs to be more recognition. The fact is, I don't think there is any later data. While we can say, this is 1995, the fact -- I don't believe anybody else has systematic data that's any later. So we may be having a lot of discussions now, and we certainly ought to tie what we're finding to the saliency of this issue, but I don't think anybody else is looking at anything more recent. They're just using a lot of anecdotal

data.

DR. LAVE: One would think that number would go down because more people join plans.

MR. SHEA: There is some data available among -- it's not published but I've seen some data from employer-provided retiree coverage which shows really alarming increases in drug expenditures, and not unexpected given the quality of the drugs that are now being made available.

DR. LAVE: But they're being paid for by whom?

DR. NEWHOUSE: The employer.

MR. SHEA: Or a mix between the employer and the employee. I'm just making the point that it seems to me prescription drugs is a bigger deal overall than is reflected in this.

MS. ROSENBLATT: I agree with that. I think that also the managed care plans would say that it's the biggest area of trend increase, mid to high double digit trend increase. So it's an increasing problem as well.

DR. ROWE: Why don't we just say that? In other words, we could just say that these data are from '95, but it is the Commission's view that prescription drugs...

DR. LAVE: But the problem is that this chapter is

focusing on per beneficiary out-of-pocket expenditures, and it is likely that the per beneficiary out-of-pocket expenditures have actually decreased between 1995 and now because more people have joined managed care plans that offer prescription drug benefits.

DR. WILENSKY: If may not have decreased because their Medigap plans have gone up and that's an important component for far more.

DR. NEWHOUSE: But the bar here --

MS. NEWPORT: But the coverage in managed care plans has changed too. There will be caps on a benefit as well as increases in copays and variable copays depending on whether it's a formulary generic or proprietary drug. So the demand is so great that where it used to be just covered with a simple copay like $5, criticism of use of formulary and demand for brand name drugs has caused the plans to adjust that benefit.

DR. WILENSKY: But these are '99 changes. Clearly, we're not going to be able to see those kinds of changes. I think it's important to indicate that these aren't '95 numbers. They're out-of-pocket. The issue has been raised, the anecdotal evidence or the reporting by

various surveys of employers and managed care companies indicates this has been a rapid area of increase. We just can't say empirically in a systematic way what this is meaning for out-of-pocket, nor can anybody else.

MR. SHEA: Right. I think the point though, Gail, that's important to make is that it is likely, that given the extent of the reports in other coverage, that this is someday going to flow or be reflected in terms of the out-of-pocket expense. Because eventually people are going to have to pay for this.

DR. WILENSKY: Absolutely. I agree, and I think we ought to note that we anticipate seeing this. We just can't say anything more --

DR. NEWHOUSE: When do we get the next MCBS?

DR. WILENSKY: That would be '96. That's not really going to show --

MR. ZABINSKI: They said it's on the way to us right now.

DR. NEWHOUSE: The '96?

MR. ZABINSKI: '96, right.

DR. WILENSKY: But I don't think you're going to see much in '96.

DR. KEMPER: One of the issues that you raise and I think is really important is how well does Medicare do for the people who have really expensive care, and how many people have a lot of out-of-pocket expenditures? How well does it do as an insurance program, put differently.

I think one finding I found somewhat surprising and relevant to that issue is your four-year analysis where you looked at whether people who were in the quartile of out-of-pocket expenditures continued in that category. I was surprised that in fact, yes, there's a great deal of persistence over time in who was in that highest category.

To me that says that whatever assessment that we make in looking at one year about how well or poorly Medicare does in covering that group, it's going to be a lot worse if you think over time. I just think it's important to bring that point out more because it suggests to me that this issue of the catastrophic coverage, which obviously everyone wants to steer clear of, is a real issue if you look over a longer period of time.

MR. MacBAIN: The implication of this kind of analysis at least to me leads into questions about how might benefits be changed, if there are issues here? And in

prescription drugs in particular, although I think it could hit some of these others as well, the data I would prefer to see would be an estimate of per beneficiary spending regardless of source on prescription drugs, and then divide that out as to how much is being paid by --

DR. WILENSKY: I don't think you can get that. I don't think it's available.

MR. MacBAIN: It just doesn't exist anywhere?

DR. NEWHOUSE: It doesn't exist.

MR. MacBAIN: The text then needs, as least as I read it, needs to be clear that all this is a small slice. I know you say it in here, but the numbers stand out. We see a number like $304, but that's only a small slice of the total bill for Medicare beneficiary prescription drugs. If you want to cover prescription drugs, nobody should walk away from this report with the implication that it can be done for $300.

DR. WILENSKY: Right, that this is literally the out-of-pocket for this element and that for large numbers of people their spending is not going to be reflected because it's covered by Medigap or by employer-sponsored. That information, even if it's technically available on the MCBS

-- I don't know if it is -- is notoriously unreliable, asking the total bill.

DR. NEWHOUSE: How would you know what percent of the Medigap premium went for drugs?

DR. WILENSKY: No, you could ask what the total expenditures for prescription drugs were, but it would be very unreliable if you did.

DR. KEMPER: But, Gail, might there not be independent data on what proportion of Medigap costs were due to prescription drugs. At least that's a number you could put in to say --

MS. ROSENBLATT: That's going to be a problem too because the two Medigap plans that cover drugs have limits.

DR. WILENSKY: Besides, that would be a really bad number.

DR. NEWHOUSE: The over limit would presumably come back to beneficiaries, so in principle that would be --

DR. WILENSKY: That ought to be in there. But I think it would just have to be clear, discussing the text. And it's not that it's not stated, but just because it would be so easy to misuse the number to be --

DR. NEWHOUSE: And getting the employer percentage

spent on drugs would be --

DR. WILENSKY: -- remind people what this number is and what it's not.

DR. LAVE: Or Medicaid on drugs.

DR. NEWHOUSE: No, that you could get I think.

MR. MacBAIN: The other point is just to underscore the need for some measure of dispersal around the mean. Because even by giving the 99th percentile, that last 1 percent has got a very long tail, so that the --

DR. LAVE: There are a number of places. There's the Pennsylvania PACE program which pays for drugs for -- but this an -- the trouble is this is not a drug thing. It's an out-of-pocket one.

DR. NEWHOUSE: That's right.

DR. WILENSKY: Right. And if we want to take that issue on, we have to take it on as a new idea.

MR. MacBAIN: I think this is the right analysis, but it could lead to some wrong implications if we don't really carefully -- whenever you put a number down, it takes on some life and some solidity and it looks real.

DR. WILENSKY: Especially if it looks like it's relevant to a current policy debate.

MR. MacBAIN: So I think it's important to say, this is real, but only in this context.

DR. LAVE: There is a question though, can you look at the out-of-pocket drug expenditures for people who have no supplemental health insurance coverage?

DR. WILENSKY: Sure.

MR. ZABINSKI: Yes.

DR. LAVE: So that would give you some sense for--

DR. NEWHOUSE: That's a selected population. There's a selection problem.

DR. WILENSKY: There's a major selection --

DR. LAVE: There's a selection problem, but I mean, the reason that it's so low is that most people have coverage.

DR. WILENSKY: Yes, because both between the Medicaid population, the SICUs, and that would tell you something but it wouldn't tell you anything much for making projections to the Medicare population.

Why don't we go on to the third and fourth --

MS. XANTHOPOULOS: I only wanted to make a couple points about the populations most affected. As we state in the chapter, this is sort of an area where we thought we'd

do more research. But clearly the oldest of the elderly are the most affected, and the first graph shows that mean out-of-pocket spending clearly increases as you get into the oldest age group.

DR. LAVE: Does that have nursing home costs in there?

MS. XANTHOPOULOS: Yes. The other trend that was apparent is that older women also do much worse than older men. That was just something that we thought we'd raise because given the demographics and the changes in the general growth in the elderly population and the fact that there are more female beneficiaries than male beneficiaries, and women tend to live longer, we think this is something that we should probably do more research on.

DR. LAVE: You may also want to point out that the damn men die and leave us alone, and put us in nursing home. And the women take care of the sick men, and that's why --

MS. XANTHOPOULOS: Actually that point was raised but we didn't include it in the chapter.

[Laughter.]

DR. ROWE: Is this per person, this figure 8?

MS. XANTHOPOULOS: The mean spending per person,

yes.

DR. ROWE: So then it's irrelevant that women live longer than men.

DR. WILENSKY: Right.

DR. ROWE: You've got people over 85 and it's per person.

MS. XANTHOPOULOS: Right, by gender.

DR. ROWE: Right, these are those men that happen to live to 85. So it's not the aggregate by all women, it's per person. So it doesn't matter that they live longer. So why do you think this is?

DR. WILENSKY: The living alone.

MS. XANTHOPOULOS: That's one of the things that we've thought about because a lot of the elderly men are married and most of the elderly women are not.

DR. ROWE: So what does that mean, they take their wives' medicine? I'm trying to follow the train of thought.

MS. XANTHOPOULOS: No, I think that the point is that more of the elderly, the oldest elderly women were in facilities, had use of long term care facilities, where the men didn't. The other thing is the income variable; that the women had lower incomes than men.

DR. ROWE: I think one of the core observations in geriatric medicine that's been repeated every time it's been over many decades -- it may no longer be the case but always has been -- is that women have greater utilization at all age groups.

DR. WILENSKY: No, not at the end.

DR. ROWE: Maybe not over 85.

DR. WILENSKY: Not even -- I think not over about 80. That reverses.

DR. ROSS: In terms of maybe not hospitalizations, but in terms of doctor visits and prescriptions and more chronic diseases. Now maybe after age 80 that's not the case.

DR. WILENSKY: No, that is not. It actually hasn't been for a long time.

MR. MacBAIN: More utilization of non-covered, non-Medicare services.

DR. WILENSKY: Yes.

DR. ROWE: So then what's the answer?

MS. XANTHOPOULOS: You mean in terms of policy, things to look for?

DR. ROWE: Yes.

MS. XANTHOPOULOS: I have ideas. I don't know that they're anything to consider, but I would think that -- I was thinking that something in terms of benefits graduated with age, because clearly the need rises as people age. I mean something has to -- given as the numbers increase and people live longer --

DR. ROWE: But I was thinking more what's the answer to the origin of this. If it's not that they have more chronic disease, and if it's not that utilization of other health care services increases with age --

DR. NEWHOUSE: She's telling you.

MS. XANTHOPOULOS: I think that that's --

DR. WILENSKY: It's presence of a caregiver, use of non-covered services, and low income. Those three things.

MS. XANTHOPOULOS: Right.

[Simultaneous discussion.]

DR. NEWHOUSE: The woman takes care of the man in the home. Then the men die and the women go to the nursing home.

DR. WILENSKY: Really it's use of non-covered services, not having a caregiver in the home, and having low

income.

DR. NEWHOUSE: But that's in here. This is beneficiary spending per Medicare --

DR. WILENSKY: Those three things together are primarily responsible.

DR. KEMPER: It's probably the case that if you took out the institutional costs you might see a different--

DR. WILENSKY: It's why I think we really need to look at these with and without long term care expenses.

MS. XANTHOPOULOS: I did do that. I did look at it without the long term care in there and one of the things is that among the elderly women, a lot of them flipped to Medicaid during that period so their costs went down. They were completely covered in the facility. So it kind of is dampened in the data, so you do see some of that effect. That is the other thing that we also would like to look at is the issue of the supplemental coverage in this group as well as turning to being Medicaid eligible during that period as well to see what kind of --

DR. NEWHOUSE: If the husband dies, does the widow lose the employer-provided retiree benefits typically.

MS. XANTHOPOULOS: I think it depends on the plan.

DR. NEWHOUSE: So what's the typical thing or is it just --

MS. NEWPORT: I think most of them do continue.

MS. XANTHOPOULOS: If it's the federal government as the employer I know that there are survivor benefit programs for them. But I think in private plans it may not be as prevalent.

DR. WILENSKY: Let me comment about Gerry's comment. We regard this as the first step of what we hope will need to some more interesting analysis. It clearly is, at most, descriptive. Maybe we can make it a little clearer in terms of intended Medicare coverage versus not. But I think that it may help us start looking at coverage or a change in coverage issue, not in terms of anticipating recommendations as much as looking at what different policy implications could be.

Stop loss coverage is certainly -- since that is such an obvious issue with regard to most insurance plans and typically not a very expensive component, what can we say about stop loss provisions in terms of what they imply, both in costs and with regard to impact.

MR. SHEA: In terms of policy recommendations that

we've done, is the only one that would be relevant here the one that we've repeated several times about the out-of-pocket costs for outpatient?

DR. NEWHOUSE: And home health copay.

DR. KEMPER: That kind of cuts the other way.

DR. WILENSKY: Yes, the only recommendation -- and it's really within the context that given everything Medicare has said it intends to do, what is actually done with regard to the outpatient is clearly deviation from that.

MR. SHEA: I wonder if it's worth putting in a paragraph, just making the point you're making, that looking forward we would like to examine policy implications here, but noting that we have addressed this in at least two areas. One of them is an issue that probably bears repeating again.

DR. WILENSKY: Yes, I think that's appropriate. That the fact that you have in a Medicare-covered service like outpatient, provisions that lead to far more than the nominal coinsurance amount is contributing to these out-of-pocket. I think that would be appropriate. But I think we ought to look at this as something that we will be turning

back to, hopefully with more interesting implications in terms of policy issues.

DR. ROWE: I may not be understanding this, Judy, as to what you've done, but if you go back to this table, how do these findings relate to the findings that were published out of HCFA about with each advancing year of age there was an increase in expenditures, but the degree of increase was actually less; is that right? That the older the beneficiary got, the incremental change in the cost of care actually went down.

DR. NEWHOUSE: I think that's right for Medicare, but not Medicare plus Medicaid.

DR. ROWE: Right, that was just the acute care setting; is that right?

DR. NEWHOUSE: I think that's right.

DR. ROWE: That didn't include long term care; is that right? That would be different than this.

MR. MacBAIN: No, this is out-of-pocket.

DR. NEWHOUSE: This is also out-of-pocket.

DR. ROWE: Right, but I'm just trying to understand it.

DR. LAVE: This includes both Medicare and long

term care services, and the use of long term care services vary by age.

DR. ROWE: Right, so that's a major difference between this and that. I think that those comparisons are informative in terms of what's relevant in the literature and how it's different from what this is -- the non-cognoscenti, including myself.

DR. WILENSKY: We're working on that though. Any other comments?

DR. NEWHOUSE: We're working on making him cognoscenti?

DR. WILENSKY: Exactly; that's what I said. Thank you very much.

Can we move back to the ESRD recommendations from yesterday that we were going to revisit?

MS. RAY: The first recommendation has been modified slightly. We flipped the order pursuant to our discussion, as well as adding at the end of the second part of the recommendation the phrase, as well as other factors related to adequacy of dialysis.

The second recommendation points out that we made these recommendations in both 1998 as well as the 1999

reports.

DR. ROWE: In just consulting my nephrologist, we might consider just using the term dialysis rather than hemodialysis, because of chronic peritoneal dialysis.

DR. NEWHOUSE: That's a good idea.

DR. ROWE: We don't want to exclude that population.

DR. WILENSKY: No, we're not intending to do that.

MS. RAY: Going onto the third slide --

DR. LEWERS: Did we do the second one?

MS. RAY: Yes.

DR. WILENSKY: Look at it first.

DR. LEWERS: I was being interrupted by my consulting. Are we going to three?

DR. WILENSKY: Look at two and make sure you're okay with two.

DR. LEWERS: The only problem I had with two is that the updates that we called for in '98 were different than in '99, and I'm wondering if we need to put the numbers in at all, calling for an increase in the composite rate? Just leave the numbers out.

MS. RAY: Yes, I agree with you.

DR. LEWERS: Because there was a difference. These numbers are from '99.

DR. WILENSKY: That's fine.

MS. RAY: The third slide, which has to do with nutritional interventions, again the sentences have been flipped.

DR. CURRERI: I had a question on that. Does enteral and parenteral nutrition include -- do those terms, would you say, include enterodialysis, introduction of nutrients during dialysis?

MS. RAY: Yes.

DR. CURRERI: Because I didn't know whether that was referred to as something else.

DR. LAVE: The question is, is the coverage of the nutritional, can the Secretary do that by regulation or does that have to be done through legislation?

MS. RAY: That's a good point.

DR. WILENSKY: There's some debate. As I understand the existing usage is following off of, not the equipment --

MS. RAY: The DME.

DR. WILENSKY: The DME coverage. It's not -- I

don't know whether -- there's some debate about whether it had to happen that way. So I don't know whether you want had --

DR. LAVE: So who do we want to direct this to? Do we want to direct this to the Secretary or to the Congress?

DR. WILENSKY: I guess our intent was, to the extent it requires new legislation, that such legislation be passed. I have at least heard some debate that -- I gather the industry is not convinced this is not something that HCFA couldn't do through its own administrative authority an use of coding.

DR. LAVE: But if you directed the Congress -- maybe the thing, if you directed it to the Congress would you be more likely to get action, or should we say something that the Secretary can't do this and the Congress should? It doesn't seem to me that we want to -- it seems to me we want to make sure that we target the recommendation to somebody who can do something about it.

DR. WILENSKY: If the Congress does it, this debate goes away. So we may want to simply put in the text that although there's some debate about whether it requires

new statutory language, if the Congress were to put this into statutory language, that would end the debate.

DR. NEWHOUSE: So the recommendation should be to the Secretary or the Congress, since this starts out, the Secretary?

MR. MacBAIN: The wording here refers to ESRD patients. We discuss this always in the context of dialysis patients.

MS. RAY: Right, but I thought that the consensus yesterday was to change that to ESRD patients.

DR. WILENSKY: Go back to this issue --

DR. NEWHOUSE: You're still back with the Secretary versus the Congress.

DR. CURRERI: Why don't we say the Secretary and Congress?

DR. NEWHOUSE: No.

DR. WILENSKY: No, we can't.

DR. CURRERI: Can't do that?

DR. WILENSKY: We may want to take out -- we may want to flip the ordering of the second sentence and say, coverage should be provided, and in the text, reference the fact that there's debate about whether this requires new

statutory language, although if Congress were to pass the language that would end it. That just, I think, acknowledges that we understand that there's such a debate going on.

DR. LEWERS: I would take out the word renal in front of benefit.

MS. RAY: Right, I wanted to make sure that it's distinguished from where the parenteral coverage is right now as a DME. I really wanted that distinguished.

DR. WILENSKY: Yes, I think that's a --

DR. LEWERS: All right, in that context.

DR. ROWE: Even though oral and enteral are the same. I mean, we have oral nutritional supplements and enteral and parenteral nutrition. Oral is enteral. So is oral nutritional supplement like a vitamin and then the enteral nutrition is like protein solutions; is that the idea?

DR. CURRERI: I think it's all right if you just take out the word oral. Because there are nutritional supplements which could be minerals or vitamins.

DR. ROWE: That's what I mean.

DR. CURRERI: Enteral and parenteral nutrition

really looks at overall intake.

DR. WILENSKY: Right, so just take out the phrase, oral nutritional supplements and --

DR. CURRERI: No, just the word oral. Nutritional supplements are different than --

DR. ROWE: Because you could even give nutrition, you can give vitamins intravenously at the end of dialysis; run them in. In fact that's not -- that's done on occasion, I believe.

DR. KEMPER: On the next one, can you remind me why we're evaluating this after we're recommending doing it?

MS. RAY: Again, there have been studies that have looked at these interventions in dialysis patients. They've been observational, there have been case reports, and there have been a couple of randomized. But there's been no large efficacy trial of these interventions.

DR. WILENSKY: Do we really think that's critical? I mean, there seems to be among the clinicians, very strong belief that this case had been proven, so maybe we ought to delete this.

DR. NEWHOUSE: Or enough proven to cover it in the interim while awaiting the larger trial.

DR. KEMPER: But I guess you can't run a large trial if it's a covered benefit because of experimentation with human subjects if you have covered benefit? And besides which, you don't usually unpass a benefit.

DR. WILENSKY: Actually, the influenza vaccine and the shoe for diabetes were subject to being shown not cost effective. So we do have some precedent where we cover something in the interim while we try to establish its effectiveness.

DR. CURRERI: But I agree. I really don't think this should be a recommendation. I think it should be in the text, but I just think it's going to be hard to do this. It's going to be hard to do the study because where are you going to get the control population? Nobody is going to sign on to take a placebo.

MS. RAY: It wouldn't be a placebo. It would be versus normal care.

DR. KEMPER: But normal care will now be nutritional supplements.

MS. RAY: I also found out yesterday that NIH is actually considering do some sort of nutritional evaluation of dialysis patients. I need to follow up on that.

DR. WILENSKY: Then that makes it even more not to have this in there.

DR. CURRERI: The only way I can see to do this is to do some [inaudible].

DR. LAVE: You have real problems with the ethics in doing that. When they had problems with AIDS --

DR. NEWHOUSE: Also it's not clear that it generalizes to here.

DR. WILENSKY: But I think we ought to take this recommendation out.

MS. RAY: Okay.

DR. LAVE: We're taking it out?

DR. WILENSKY: It doesn't make any sense.

DR. LAVE: They can do research.

DR. LEWERS: I'd like to revisit the first one here on whether we take out the word oral. The problem here -- and Nancy can help us on this -- supplements are basically provided where there is gastrointestinal disease, enteral disease, if I'm not mistaken. So I'd almost like to reword that to say, patients to be eligible for nutritional supplements, either oral, enteral, or parenteral. I've got a number of people who, or have had, that have feeding tubes

and we put it in there. I don't want to basically eliminate the oral.

The big problem is -- and I agree, we don't have the basic data -- but whether or not the oral will work, and many people feel they do. That's the problem that we really have. So I would put nutritional supplements, either oral, enteral, or parenteral.

DR. ROWE: But doesn't enteral include oral?

DR. LEWERS: But if I put a feeding tube it's not oral.

DR. ROWE: Right, but it is enteral. If you take it by mouth it's enteral, and if you put it by feeding tube it's enteral.

DR. LEWERS: I would rather leave it in. I don't think it does any harm. I mean, if they think we're idiots because we don't know the difference between oral and enteral, then that's fine with me. But I would prefer we leave it in.

MS. RAY: The last recommendation is the new recommendation about, to fulfill the requirements of the BBA regarding improving the quality of dialysis care. The Secretary should take into consideration quality assessment

and assurance efforts of private renal organizations.

DR. CURRERI: What are the private renal organizations? What's the word private -- is that for-profit or not-for-profit?

DR. WILENSKY: Non-governmental.

DR. LAVE: Why don't we just take the word private out and say, renal organizations?

DR. WILENSKY: Fine.

DR. CURRERI: That's what I think.

DR. NEWHOUSE: So it would be better to say, in fulfilling, since the BBA didn't -- kind of imply that she should do this. In fulfilling the requirements of the BBA.

DR. WILENSKY: Okay. Thank you. I think this captured the sense of the discussion yesterday very well.

We're going to do one more session.

DR. ROSS: If I could just make a couple of housekeeping comments to commissioners. That is the end of discussion of chapters for the June report. I just want to remind you, if you have written comments to please leave them with us because people will be working over the weekend on this. The other is, we will get back to you as soon as possible, I hope Monday, by fax or e-mail with revisions to

the home health recommendations, so you'll have a chance to look at those and weigh in, and if need be we can conference on them. But we'll try to reflect all your comments as fully as possible.

DR. LEWERS: Did we make it clear for our guests that we omitted Tab I, that it wasn't available? I don't want anybody sitting out here thinking we're going to talk about access when we're not. I don't know whether that was out front or not.

DR. ROSS: We may not have put out an updated schedule, but we will not be doing Tab I for this report. We'll bring that back to you, I am presuming, as a retreat item.

DR. WILENSKY: Let me also ask if there are any public comments before we go into the next session, if anyone wishes to make them.

Okay, Sarah?

MS. THOMAS: I'm just going to take a few minutes and brief you all on our extramural research study to look at health plan selection and payment of health care providers. We commissioned this study with three basic kind of objectives. First of all, we wanted to understand how

Medicare+Choice regulations relate to normal practices. In other words, whether plans do things different for Medicare and why.

We also wanted to be able to look at innovations for managed care and think about how they potentially might be adopted in fee-for-service. And we also wanted to be able to contribute to the general literature on features of the health care system. The 1994 study that PPRC commissioned was extremely useful for health services research in this area.

Milestones on the contract. We awarded the contract to Mathematica Policy Research and the Medical College of Virginia. The principal investigators are Marsha Gold and Bob Hurley. The survey is intended to produce interviews with 100 plans, all of which we decided later to make HMOs and 70 what we call intermediate entities. These are groups of providers at global risk for the health care service. That is, they're at risk for more than their own services, and in our view would include hospital and physician care together.

At this point, Mathematica has completed the literature synthesis. We had an expert panel meeting. The

results of that are summarized in your mailing materials. At this point we're in the process of revising the plan survey and beginning to think of a sampling frame for the intermediate entities. We expect to have -- the survey will be in the field all summer and we'll have our results in the fall.

I just wanted to quickly give you a sense for the content of the plan survey. The first area is the type of products and covered lives in each, whether these plans are traditional HMOs, HMOs with POS options, PPOs; the extent to which products are offered to self-insured employers; whether they offer Medicare products and the types of products those are.

We also are going to ask questions about whether plans used to offer Medicare products in the past three years; why they dropped the product; why they decided not to offer a Medicare product; and their future plans to offer a Medicare product; and whether they've changed their service area for Medicare and why.

We're also going to ask whether in their 2000 ACR filings they changed their pharmacy benefit, dollar limit in particular, and changed their premiums. And we're also

going to ask them whether they offer Medicaid managed care products, whether they have dropped one and why.

So we view this section as a chance to get in there and get some feedback on the perception of Medicare as a business item.

The next area is network strategy and organization. This is basically going to tell us the way the plan network is structured. We're looking not only at physicians, which is what the focus of the '94 study was, but also hospitals, nursing homes, and home health agencies.

We're going to elicit plans preferred types of contracting arrangements and how they're allocated by covered lives. For example, the share of covered lives and physicians under salary, direct contracting groups in IPAs, PHOs and similar kinds of questions for other providers.

Then there's a series of questions in this area on network selection process. Whether they have a preference for contracts that cover multiple sites of are, importance of price negotiation to selection, and the preference for a large or small network. Also their reasons for dropping physicians and for physicians withdrawing from plans.

The third area, comparing traditional HMO networks

to Medicare networks looks at whether the network of physicians is the same in the counties where Medicare and commercial products are offered. And if not, what overlaps there are, whether there are reasons for the differences, whether providers can limit their participation in the Medicare product, and whether there are overlaps also in other provider types.

The fourth area here is the payment to individual providers and facilities, and this is comparing practices for commercial and Medicare products. We're going to ask about the predominant payment method for physicians, services covered under capitations, whether they use withholds and bonuses, percentage of compensation at risk, and payment method for specialists. Whether the plan uses performance measures to establish compensation of payment, satisfaction surveys, and other factors that they might use in reimbursement.

And the final area is identifying the intermediate entities. This is to establish a sampling frame for the second part of the survey. So there's an overview if you have any questions.

MR. MacBAIN: Will the survey drill down to the

individual provider when you have multiple layers such as the network that pays a group?

MS. THOMAS: We'll get to the intermediate entity.

MR. MacBAIN: You know, the HMO pays a network, the network pays a medical group, the medical group pays the doctor. Will the survey drill --

MS. THOMAS: We'll only get the first two levels. But when we get to the second level we'll ask about the relationships downwards.

MR. MacBAIN: Because what actually happens in the pay --

MS. THOMAS: We can't get all the way down to the individual doctors, but we will document what the middle say they do with the bottom layer.

MR. MacBAIN: But it's that final level, that's where the interesting --

MS. THOMAS: We are planning some site visits as well so we can explore that complexity.

MR. MacBAIN: And similarly with super PHOs, and PHOs, and POs, and how the PO -- you know, the physician gets a fee, but also then has some sort of residual risk sharing arrangement. It's what actually comes together in

the mind of the physician that's important.

DR. ROWE: Is that what you mean by the intermediate entities, like the MSOs and the PHOs?

MS. THOMAS: Yes, exactly.

DR. ROWE: What happens if a plan drops out of the Medicare+Choice program between the time that you start the study and -- now you've identified these 100 plans and when you're collecting data or when you're reporting it or whatever?

MS. THOMAS: We're not selecting them on the basis of whether they contract with Medicare at the time of the sample. I mean, that's sort of a first screening question and then there's a battery of questions that ask them, if you do do Medicare, how do you do things differently? And there are questions, have you recently dropped a Medicare product, so we'll be able to pursue that if that's the case.

DR. KEMPER: Have you drawn the sample?

MS. THOMAS: Yes, of the HMOs. We haven't of the intermediate entities because that relies on the questions to the HMOs.

DR. KEMPER: Can you explain to me the issue about PPOs and whether they're in or out?

MS. THOMAS: It was a difficult decision because we originally thought that we would include HMOs and PPOs, and we really, given this whole issue about PPOs not feeling they could participate in Medicare+Choice because of the types of plan standards, we wanted to have a better understanding of what PPOs are about.

Our panelists told us that they thought the real contribution of the study was to really explore the intermediate entities and that we would find very little variation of interest in the PPO world. That we would find that they do things not as interesting, not as exciting, not as diverse as what HMOs do, and that would be our finding. And that the chance to include more intermediate entities shouldn't be passed on.

DR. KEMPER: I guess I would probably agree with that. But then it seems to me we need to find some other way to address this issue of PPOs --

MS. THOMAS: I think that's a good idea.

DR. KEMPER: -- and what roles they might play --

MS. THOMAS: What they're about.

DR. KEMPER: -- and what the barriers are, and so on. It sounds like it won't be this study, but some other

way of getting at that issue.

MS. ROSENBLATT: I thought the write-up of what the panel said did a real good job of indicating all the problems with doing a survey like this. I noticed in the schedule that the survey is being pre-tested. How is it being pre-tested? Because I think it's going to be -- this is a very, very difficult thing to do.

MS. THOMAS: Through an interview with a plan.

MS. ROSENBLATT: With a plan?

MS. THOMAS: I can't remember. I think may be more than one. But they're interviews with plans. I do not remember how many.

We also have asked our panelists to help us find people.

MS. ROSENBLATT: I was going to suggest that because you clearly had a good panel there, and if you could get their help in reviewing this survey instrument that would be a good idea.

MS. THOMAS: Absolutely. It's been a good job for them to do so, but I think we've winnowed down the survey instrument to something that's considerable to do.

DR. LAVE: I have sort of an observation and a

question. The observation is that I think that we ought to have a search and replace so every time fee-for-service medical care is there it should be replaced with traditional Medicare.

The second issue is, would it be possible to get a copy of the survey?

MS. THOMAS: Sure.

DR. LAVE: It might be helpful for us to have copies, and then when we get a report back we will have thought about some things that we may want to ask, or even people like Janet and Alice might sort of just have an epiphany.

[Laughter.]

MS. THOMAS: Could those of you who are interested in getting a copy e-mail it? That would be the best, because I don't want to have to make a bazillion copies of things that some people might not be interested in.

MS. NEWPORT: I think this is really going to be an interesting study. I'd suggest -- and I don't know how this is going to mess up your survey numbers, but you may get a couple of levels of response depending on, for example, with PacifiCare, going to the corporate folks as

opposed to those that are in the market actually doing the contracting. It might be interesting to amplify, maybe on a background basis, what you're seeing. Because you know, you've seen one provider contractor, in my nomenclature, you've seen one provider contractor.

So I think there's a global style that some companies try to establish, and then there's the market reality. I think that, again, you might want to explore that and not destroy your sample size. But it would be worth going after that.

MS. THOMAS: I think that Marsha in the past has gone first to the corporate office, just so we get permission to then pursue it. So we can talk about how to--

MS. NEWPORT: Just a suggestion.

DR. WILENSKY: Thank you. Gerry?

MR. SHEA: Are we going to get much of a picture of what the contracts convey about developing consumer information, or reporting? You mentioned performance measurements and so forth in relation -- it sounds like the financial --

MS. THOMAS: Only as they -- we're interested in those as they relate to the primary research questions of

how do they select and how do they pay? So we would ideally like to cover the ground that -- in the PPRC study they actually looked at quality and performance measurement, and we just felt -- and we're having a hard time keeping the survey down to focus on these core issues. So that would be a valuable line of pursuit, but we didn't want to overburden the respondents.

MR. SHEA: It seems like, in terms of how they select, the extent to which they include in their selection criteria willingness to -- you know, the sort of thing that's found and could be useful, if not now, then --

MS. THOMAS: Right.

MS. NEWPORT: There's some challenges in that area in terms of limitations and what is considered by HCFA to be appropriate to require the physicians to do or the provider group. So there are some bright lines that they shouldn't be crossing and it gets into some fraud and abuse areas. So I think there's ways to get to the answer to your question, but they may not be embedded in the contract as part of -- other than quality assurance and utilization review and maybe some claims processing.

So communication with the members is a real firmly

established process that has to go through HCFA and the plan. So there's a way to get to your answer but I think it may not be for the purposes of this study.

DR. WILENSKY: Thank you.

DR. LEWERS: Just a brief -- in looking at the panelists, and I think the input would be good to have a practicing physician. These physicians all work for plans or academia. I think bringing that concept in might be helpful if you can add them. Maybe some of these do practice, but at least the titles indicate otherwise.

MS. THOMAS: Okay. Thanks.

DR. WILENSKY: We're going to break now for lunch, which is early. We're going to reconvene at 12:45, also a little early. Because people may have been planning to come back for the discussion on the physician updates, we are going to start with Jack Ashby's presentation, so we will not start earlier than people are anticipating for that presentation.

[Whereupon, at 12:04 p.m., the meeting was recessed, to reconvene at 12:45 p.m, this same day.]

AFTERNOON SESSION [12:53 p.m.]

DR. WILENSKY: Jack?

MR. ASHBY: We are in the beginning stages of a project that will measure how much care Medicare beneficiaries from VA and military hospitals. We expect the results of that project to allow us to develop and test an adjustment to Medicare+Choice rates to account for the covered services that VA and DOD provide.

To start things out, Tom is going to give us a little background on the problem that led up to this project, and then I'm going to go over some of the policy issues involved and summarize our plans for this rather major project.

MR. KORNFIELD: This slide here basically gives the relationship that is at the core of the problem. The Medicare+Choice rate is determined -- let me back up a second. This really has to do with the 1997 base rate, but for all intents and purposes this is the Medicare+Choice payment rate.

The way it's calculated is that HCFA first calculates in each county the Medicare fee-for-service spending and then it divides by the number of Medicare fee-

for-service beneficiaries. So then it gets a spending per beneficiary in each county, and there are adjustments that are done later for -- there are risk adjustments and that sort of thing. But that's the basic essence of it.

The problems that are pointed out in the slide are what our study is -- the reason for our study -- is that, you see in the top that the payments for the fee-for-service services do not include the services that are provided to Medicare beneficiaries who are also eligible to use Department of Defense and Veterans Affairs facilities. So it doesn't include those. But it does include them as the number of beneficiaries in the county. So what you can end up with is an understated fraction, if you will, because the numerator is understated relative to the denominator.

Now ProPAC analyzed this problem in 1996 and in their report found that an add-on adjustment of 3.2 percent, which would be an increased 3.2 percent, would account for the change. That's about 2.6 percent related to Veterans Affairs and .6 percent related to Department of Defense.

DR. LAVE: That was a national number?

MR. KORNFIELD: That's a national number, yes. The state numbers vary quite a bit. The highest is 8.2

percent in South Dakota, and the lowest is 1.2 percent in New Jersey.

DR. CURRERI: Can I interrupt you for a second?

MR. KORNFIELD: Yes, go ahead.

DR. CURRERI: I think we discussed this last year and I was racking my brains last night, but isn't part of this effect offset by the inclusion of DSH payments in here, or am I wrong about that? I remember it was offset by something.

DR. NEWHOUSE: No, this is something else.

MR. ASHBY: No, this is really a separate issue.

MR. MacBAIN: The dollar amounts happen to be pretty close.

DR. ROSS: The dollar amounts are similar.

MR. MacBAIN: But county by county, facility by facility, plan by plan --

MR. KORNFIELD: This slide here gives an example of where we think this suppression of rates has occurred. The slide gives you three metropolitan statistical areas in the state of Ohio. It's the Cincinnati statistical area, Dayton-Springfield metropolitan statistical area, and Columbus MSA.

There are five counties that are shown there in that graph, and the one of interest to us is Green County. You see in the upper left-hand corner of Green County, that's where Wright-Patterson Air Force Base is located. Now as you can imagine, that's a significant facility in that area, and if you look at the slide you'll see that Green County's payment at $404 is the lowest among the counties shown. And those are all urban counties. It's 13 percent lower than the average of the five urban counties that border it.

I also want to point out that this is actually -- one of the reasons that we started to look at this was related to the plan pull-outs from last year. Four of the bordering urban counties of Green County have more Medicare+Choice than Green County. Each of them has about three each.

Green currently has two Medicare+Choice plans. But last year they only had one Medicare+Choice -- they had one risk plan -- the Medicare+Choice program hadn't started yet -- and that plan was Anthem. And that plan announced in the middle of the year they were going to withdraw, and then there was some political pressure and as a result of that

Anthem did stay.

But I think -- I'm going to talk a little bit later about plan pull-outs kind of more broadly. But we see here that this suppression we think may have had an impact on Anthem's decision.

I'm going to turn it back over to Jack for the remainder of the presentation.

MR. ASHBY: The solution to the problem that Tom has laid out for you, or I should say perhaps the potential solution, is to estimate how much Medicare would have paid for the covered services that VA/DOD provide, and then to adjust each Medicare+Choice rate at the county level accordingly. As we see in this next overhead, perhaps the logical way to structure such an adjustment is as a percentage add-on to the base rates, and that add-on might range from virtually zero to we really don't know what the high end would be.

Then the actual rates would have to be computed. And it's quite possible that the minimum rates would obviate the need for the VA/DOD adjustment in at least a few counties, and the blends would indeed have an effect also. Although a 50/50 blend could only offset part of what a plan

would get from an adjustment, the question is what part?

One of the key policy questions that would arise if we seriously consider this option is whether the VA/DOD adjustment should be implemented on a budget neutral basis.

DR. ROWE: Jack, can I ask a quick question?

MR. ASHBY: Sure.

DR. ROWE: We had talked last year when this issue first came up of the VA and the Department of Defense, it was VA/DOD, Indian Health Service as I recall the discussion. The Indian Health Service seems to have dropped out now. Is that just because those are non-overlapping populations in terms of Indian Health Service people don't -- they get all their care from Indian Health Services and none from Medicare, or how does it work?

MR. ASHBY: I think that is largely the case. But there's another -- they're not really that overlapping. But there's another factor as well, and that is that evidently Indian Health Service hospitals can bill Medicare when an eligible person comes along, which neither the VA nor DOD can. So that changes the equation too, and all things considered, we thought we would not put them in there.

DR. ROWE: Thank you. We might include a comment

about that or something, because that was one of the questions I remember from last year.

DR. WILENSKY: Yes.

MR. ASHBY: The question of whether this would be done on a budget neutral basis. I think there's perhaps an argument to be made that perhaps it should not be done budget neutral, and that is because we have risk adjustment going in and that's expected to lower rates, correcting for the effects of past favorable selection. So this adjustment could be allowed to raise rates as a correction for the suppression that we have seen in the past. The combination of those two changes together might be viewed as producing the most accurate set of rates possible within the overall constraint of using fee-for-service data.

Now the next issue is a surprisingly complex and perhaps politically loaded one as well. That is what to do about beneficiaries who enroll in a Medicare+Choice plan, supposedly so that the plan will be in a position to meet all of its needs, at least for covered services, but then the beneficiary goes right on using the VA or military hospital as if nothing had changed. We have heard complaints from both the VA and the DOD about this. They

tend to view it as a windfall for the health plan.

But when we take suppression into account that's not actually necessarily the case.

DR. LAVE: When you take what into account?

MR. ASHBY: The initial suppression of rates. In other words, the plan is getting an arbitrarily low rate, but then they offset some of what they might lose there by not having to provide some of the care in the new arrangement.

So the question becomes, what are the relatives for these two parts of the problem?

We have a recent study now that was done by a Dartmouth researcher for the VA that suggests that the risk plans, on average -- and on average is a key part of this -- get back perhaps about half of what they lose in suppression of rates by their enrollees continuing to obtain care in the VA and DOD. So on average they are still losing, as it were.

DR. NEWHOUSE: Is that just the VA or also DOD?

MR. ASHBY: No, this is only VA, because only the VA has looked at it.

DR. ROWE: Is that just at the White River

Junction VA or is that for a system-wide study.

MR. ASHBY: That's a system-wide study, and it's approximately half. We don't doubt that the same phenomenon is going on in Department of Defense but there is no data on that side yet.

But on the other hand, if we were to eliminate the suppression of rates by implementing this Medicare+Choice rate, then we indeed would have a situation where the health plan would gain a windfall every time one of its patients obtains a medically necessary and covered service from the VA or DOD. So I think it's fair to say that we would have to find some way to resolve this question before Congress would agree to legislate a VA/DOD adjustment.

There are basically three ways that this might be handled. I have to say right up front that all three of them have both advantages and disadvantages. This is not a clear question at all.

First option is to restrict Medicare+Choice enrollees from obtaining care in the VA and DOD. That parallels our policy that restricts these enrollees now from obtaining care in the Medicare fee-for-service. What you're in essence doing is extending that policy from Medicare fee-

for-service over to VA --

DR. WILENSKY: For only covered services.

MR. ASHBY: Yes, for all covered services -- kind of over to VA non-fee-for-service; same concept. Whether that would be politically feasible is a serious question, as you might all imagine. It might make conceptual sense. It might not make any political sense, but we can discuss that.

The second option is to require the VA and DOD to bill a health plan when they treat a Medicare+Choice enrollee. That essentially treats the VA and DOD as an out-of-plan provider in a provider services plan. Again you might say that makes some conceptual sense. One of the problems it brings on though is that it would require both the VA and DOD to make substantial system investments to gear up, to identify, and bill. They tell us they are not at all prepared to do this. They have not ever had to do it before.

Then I would add that both the VA and DOD have voiced some concern. They don't necessarily know any more than we do, but they at least expressed some concern that either one of these first two options might reduce the demand for their systems, and for obvious reasons they're

nervous about that.

So that leads to the third option, and that is to make an upward adjustment in the base rates to account for use of the VA and DOD systems by fee-for-service beneficiaries offset by a downward adjustment for use of the VA/DOD systems by HMO enrollees. That would work and it would seem fair. It would reduce the incentives involved for either health plans or beneficiaries to do anything -- in particular, remove the financial incentive.

DR. LAVE: What difference does it make to the beneficiary?

DR. WILENSKY: It's just a payment to the plan.

DR. NEWHOUSE: This is all independent of the beneficiary.

DR. LAVE: Right, so it doesn't make any --

MR. ASHBY: It would leave the beneficiary with free choice is what I meant, which neither --

DR. ROWE: I don't understand the first of those two under three. These Medicare+Choice programs, are these all capitated?

MR. ASHBY: These are people who have now enrolled in an HMO.

DR. ROWE: Right, and this is all capitated?

DR. WILENSKY: Right.

DR. ROWE: So what is the fee-for-service? Who are the fee-for-service beneficiaries in the capitated program?

MS. ROSENBLATT: No, the base rate. The fee-for-service beneficiaries --

MR. ASHBY: You're talking about the first triangle under number three here?

DR. ROWE: Yes.

MR. ASHBY: The base Medicare+Choice rates, of course, are based on services obtained by the fee-for-service population, or the traditional Medicare population. That measurement --

DR. WILENSKY: He's just talking about the rate.

MR. ASHBY: Right, we're talking about the base rate.

DR. NEWHOUSE: That's suppressed by when they go off and use the VA/DOD, because that's not in the --

DR. KEMPER: But not on an individual patient basis, but in calculating the -- making this adjustment there would be two parts to it, the fee-for-service --

MR. MacBAIN: Call it traditional Medicare.

DR. WILENSKY: You're just doing an offsetting adjustment both for the fact that it's understated because you don't --

DR. ROWE: So that in calculating the M&C rate you're taking into account those two factors.

DR. WILENSKY: Right.

DR. ROWE: One is how much traditional fee-for-service there is in that -- what dilution effect or suppression effect there is.

DR. WILENSKY: Right.

DR. ROWE: And then the second is --

DR. WILENSKY: The savings.

DR. ROWE: -- a partial capitation rate --

DR. WILENSKY: Partial offset.

DR. ROWE: -- for those people who are --

DR. NEWHOUSE: No, it's an offset. It's not a --

DR. WILENSKY: It's a partial offset.

DR. ROWE: It's an offset who are getting care also from the VA or DOD?

DR. WILENSKY: Right.

MR. ASHBY: Exactly. And just to complete the

profile, our sense is that the first adjustment would be about twice as large as the offsetting one. So that part of the problem is taking care of itself. We're adjusting for the rest of it, is the way to look at it.

DR. ROWE: That would have the advantage of not asking the VA or the DOD to establish billing capacities to solve our problem.

DR. WILENSKY: Right. And also not trying to stop the beneficiaries' ability to go to both these places just to make --

DR. ROWE: That's a non-starter. Doesn't the VA give medicines, pharmaceuticals?

MR. ASHBY: Yes.

DR. ROWE: So they go to the VA for their drugs, and then they go to --

MR. ASHBY: Right, but we're only talking --

DR. WILENSKY: But that's not an issue, because that's a non-covered service.

MR. ASHBY: Exactly. We're only talking about covered services here.

DR. ROWE: That they could get at the VA/DOD.

MR. MacBAIN: It is an issue in the sense of I

guess what amounts to moral hazard between these two plans, when you've got beneficiaries fully covered under two plans at the same time. If one of them covers prescription drugs and the other doesn't, then there's an incentive for those people who are sick enough to need prescriptions to see the doctor in the plan that covers the prescription drugs to be sure they get their prescriptions. There also is an incentive for --

MR. ASHBY: Which is, of course, the case today as well.

MR. MacBAIN: Yes, it's there now. But just to be aware of it --

MR. ASHBY: It's there now. This would not eliminate it.

MR. MacBAIN: There also is an incentive, if both of those are being held accountable for their bottom line cost, there's an incentive to try to push the sickest patients into the other system. That's true of health plans now. It's increasingly true of VA, and I suppose DOD as they go on a capitation basis. So we need to have some sense of what's producing the cross-over.

MR. ASHBY: Except that to the extent that -- in

fact this leads me to the next point I was going to make. That is, the problem that you have with this third adjustment is that it would have to be periodically updated because the dynamics would change.

MR. MacBAIN: Also, do we know how much this varies from one place to another? For instance, the appeal of White River Junction may be quite a bit different from the appeal of the services available at Wright-Patterson Air Force Base or in Pittsburgh where the VA facility is a nursing home.

MR. ASHBY: But both of these components of the adjustment are area specific. So in one area, the second adjustment for use by Medicare+Choice enrollees might be nothing. In another area it might be enough to completely offset --

MR. MacBAIN: It's area specific and it's dynamic.

MR. ASHBY: Exactly.

DR. LAVE: How does the VA know where the person is enrolled? There would be a link through the Medicare data?

MR. ASHBY: Yes.

DR. LAVE: Because the VA and other insurance data

is not pristine.

MR. ASHBY: Right. Judy, that's what we're doing in our project, if you will. So we'll get to the project in a minute, and we are going to solve that problem we think; we hope.

Now I just would leave this issue with the thought that obviously we don't need to resolve this now, but we do have the sense that we would have to settle on one of these options before we could implement the adjustment. That's really the message I wanted to leave you with today more than anything else.

Now you gentlemen sound like you're still debating one of these.

MR. MacBAIN: I'll talk while they're debating.

[Laughter.]

MR. MacBAIN: This reminds me a lot of the problem with the working elderly, the working Medicare beneficiary back in the early days of the Medicare risk program before they were excluded from the calculation of the AAPCC. The way the health plans compensated for that was to try to enroll a proportionate share of those folks in the plan.

Is there any indication that health plans are

compensating in the same way, recognizing that these folks have other coverage and so they're going to be less expensive to the plan, and go out and enroll DOD and VA beneficiaries?

MR. ASHBY: We have heard some anecdotal suggestions of that, that some of the plans like these people and sort of encourage them to --

MR. MacBAIN: It becomes a self-correcting problem, at least --

MR. ASHBY: -- encourage them to use the VA and military hospitals.

DR. WILENSKY: But not from Medicare's point of view.

MR. ASHBY: But by the same token, you also have to realize that the military hospitals and the VA hospitals want these people as well. It's not like they're being shoved off on them. Generally, they're looking for the volume as well. In fact they're skittish about losing the volume.

So you can't characterize it as any kind of a dumping thing or what have you. It's more of an active recruitment or active interest in these patients by both

sides.

DR. ROSS: Bill, you can actually test for that then by looking at penetration rates in areas of high concentration.

DR. KEMPER: You said that we could just put this aside, but I think it does affect how one views the study because option three, if I understand it right, cuts the magnitude of the adjustments in half.

MR. ASHBY: Yes.

DR. KEMPER: So it becomes less of a deal if --

DR. WILENSKY: No, just numerically it's --

MR. ASHBY: No, I think Peter is right. You would end up with a smaller adjustment when all is said and done under option three because you're not diverting care away, whereas you are diverting care away potentially in both number one and two. So that is part of the picture here.

DR. KEMPER: Frankly, I think option two has problems with it because if the health plans are going to pay for these services then I would think they would want to control access to them. So that's almost taking away the benefit --

MR. ASHBY: Right, and one would think that there

might be some discouragement probably.

DR. KEMPER: Some considerable discouragement.

DR. WILENSKY: Why are we talking about this? One is a legal issue of entitlement. Two is just such a political non-starter. I mean the question is, is three interesting?

DR. NEWHOUSE: Is there any problem with three?

DR. WILENSKY: Yes, I think the question is, is there a problem with three, because one and two are, in principle, options, but they make no sense.

MR. ASHBY: My sense is that the answer to that is that three is perfectly workable except that it is the analyst's dream, if you will, because it would have to be kept up and we would be doing a lot of data collection and analysis for a lot of years to come.

DR. WILENSKY: Don't you think you would do it once and try to get a sense about how much difference it made before you would recommend how often?

MR. ASHBY: You would. But I think it's worth understanding that the first adjustment, the one for fee-for-service, does not need to be updated regularly. All you're doing in that first one is taking your community

measurement and making it a little more accurate. Once you have done that, it doesn't really matter whether the mix of services changes between any of the three players. It's only the total that you're interested in. So that dynamic can stay relatively stable for years; relatively stable.

DR. LAVE: But the VA --

DR. NEWHOUSE: Also, you may have a lot of noise in your first year estimate.

DR. LAVE: You may have a lot of noise in the VA and --

MR. ASHBY: I know, but all I'm pointing out is that the second one is far more volatile because all it takes then is for a hospital to close, or for a new plan to come in, or virtually any other normal dynamic and, whoa, your number is off. So if you didn't update it at least maybe every three years, if not every year, pretty soon it just would not be accurate at all in some areas. So that's the problem.

DR. WILENSKY: I know, but don't you -- I mean, it strikes me that if ever there's -- this is an empirical question and until we try it we don't know how significant it is. It may be that when you get all done, for most parts

of the country, the net impact is not worth suggesting making this a triannual or biannual exercise.

MR. ASHBY: Exactly, right.

DR. WILENSKY: But it's the kind of thing you only know after you do it.

MR. ASHBY: And Gail, we'll know that, of course, after we do the study. My guess would be, if I had to guess, that in many areas of the country that's exactly what would happen. It would really be kind of a minor matter. But there probably will be some specific areas of the country where it matters a great deal, and especially matters to them.

DR. WILENSKY: Then the question is, can you make a recommendation that you actually carry it out more frequently only in some -- but this would be the kind of thing where there's no reason to prejudge --

MR. ASHBY: Exactly. So we would have to assess whether it was worth it at that point.

DR. ROWE: First of all, I think the fact that it may be an analyst's dream is not necessarily a reason to rule it out.

MR. ASHBY: I wouldn't think so either.

[Laughter.]

DR. ROWE: I think the principles here are important. It's important for us to enunciate some principles. One of the principles is, this is our problem, not the beneficiaries' problem. This should be transparent to the beneficiaries. That's principle -- and whatever solution you get to, you've got to test them against these principles.

Number two, this has to be cooperative. We really need to make sure the VA and the DOD understand what we're doing, why we're doing it, et cetera, and the plans, et cetera. There has to be some kind of evidence of cooperation and communication.

Number three, we have to take a look across the country at -- there is tremendous heterogeneity with respect to market share in the VA on a local basis and with respect to health plan penetration, Medicare+Choice penetration. There may be one or two places that are particularly susceptible to unintended effects here. I think you're going to be able to predict that ahead of time and we should be aware of that, and identify those, and have some sort of a way to deal with that a priori so we don't get killed six

months into it.

DR. WILENSKY: But I think these are the kind of -- I don't disagree with you. It would strike me that what we ought to do is do the empirical study, and then when we come to looking at the policy implications and recommendations then we have to be sensitive to those.

MR. ASHBY: Let me add, by the way, in terms of that cooperative effort that part of the backdrop here is that the same Medicare+Choice base rates are being used in this Medicare subvention demonstration, which is essentially allowing military facilities to act as another Medicare+Choice plan. So to the extent that the rates are suppressed in Medicare, they're also suppressed for the other side, and the other side is aware of that and that's part of the reason why they're enthused about this, for good reason.

MS. ROSENBLATT: I agree with doing the analysis and your method three meets sound actuarial practice, I guess I would say. It makes sense. It's the way an actuary would adjust --

DR. NEWHOUSE: An actuary's dream.

[Laughter.]

MS. ROSENBLATT: An actuary's dream as well as an analyst's dream. Let me just add one thing that I'm worried about without having enough brain capacity right now to think it through. Because the '97 base rate then gets adjusted by all the blend and everything else, it would seem to me that you could end up over time with this becoming a negative adjustment if you don't go through it quickly.

So it would seem to me that the analysis would not just need to take a snapshot but would also need to look at what -- if the next update is going to be done in three years, what's going to happen in three years?

MR. ASHBY: Right. That's a very good point, Alice, and we'll try to --

MS. ROSENBLATT: Maybe there's more brain capacity left than I thought.

MR. ASHBY: We'll try to take that into account. Although as you can imagine, it's going to be sort of difficult to know. But it's very important to keep in mind.

MS. ROSENBLATT: The other comment I would add, is that I know the staff has limited resources and there's a lot of work. My personal opinion, without understanding the variation by area, is that we're going for a degree of

precision that is very great here compared to the precision in the risk adjustment. And I personally would rather see staff resources spent on risk adjustment I think.

DR. KEMPER: I'd like to echo that in two respects. One is that it seems to me that the adjustment is likely to be greatest in rural areas where, if they're like other rural areas, entry of Medicare+Choice plans is unlikely in any case. So that there's sort of a catch-22 here. The place where we're putting the most resources is almost by definition, since the base has a big effect if it's in a rural area, the place where it's likely to make the least practical difference.

DR. NEWHOUSE: There's places like Charleston, South Carolina where it's --

DR. KEMPER: There may be exceptions to that --

DR. WILENSKY: Or Wright-Patterson.

DR. NEWHOUSE: Or San Diego.

DR. KEMPER: I guess the other question that I have is, we have in the back of our mind this problem that the Medicare+Choice rates and the fee-for-service average is going to get further and further apart in some localities over time as the blend kicks in and the floors kick in. I

wonder whether by the time this gets done and actually gets implemented whether or not we may not have to deal with a much bigger problem than this particular problem.

Now maybe this problem would be a part of that, of solving that problem. But it seems to me some thought ought to be given to how this effort fits into that effort, which is maybe several years in the future, but not a small issue I think.

MS. NEWPORT: I think three makes the most sense, and the idea of spending a lot of time on this when there are maybe issues of more acute interest I think is correct.

As I recall, we did some work several years ago on the CHAMPUS project and military retirees, 60 percent of them retire where their last posting is, and they do try to optimize -- San Diego is obviously huge for the Navy. It's a lovely place to retire to. So I think that there is a way to get at some data in terms of how acute the payment disparity might be and maybe rule out some places. You know, retirement in the middle of Kansas may not be as optimal as another place. So there's a way to maybe segment this where this problem is most acute.

DR. LAVE: Jack, I remember we did this exercise

before.

MR. ASHBY: Yes.

DR. LAVE: So certainly we can do that for two things, one of which is, if you're not going to do the nation as a whole default, just use the data that you had before to decide where to do more analysis. And secondly, the differences between what the add-on would have been when it was done before and what the add-on would be now would give some sense to Alice's question about what are the long term dynamics for this.

MR. ASHBY: Right.

DR. LAVE: So I think that it is important to realize that this is not really -- it's a new project, but it has been done before.

MR. ASHBY: That's a good point.

DR. KEMPER: Not at the county level though. Isn't that the big --

MR. ASHBY: Yes, I was going to make both of those comments. One is that we did not do it at the county level before and we sort of wished that we had after the fact. But the other side of it is true and that is that we have forged relationships and protocols for doing this so we're

not starting from scratch the way that we might have. So it's a little more doable than you might think, notwithstanding what I was going to tell you in a minute about progress on the project.

DR. LAVE: But you could still look at the county rate differences. If it turned out that they were relatively stable over time, you would know that the relationship was relatively stable over time. So there is some information that you can take from the old project that would allow you to get some idea about whether or not the interrelationship between the fee-for-service sector and the Medicare and VA is subject to dramatic changes.

DR. ROWE: Isn't the problem that we're all kind of scholars more interested in this experiment and it's really not that important?

DR. WILENSKY: I'd like to make a suggestion. I think it's important we have an update on where we are but I'd like to withhold some of this discussion until the retreat because I think we're not taking this in the right context. We need to know where you are and if there are problems, but I think we ought to wait because it's a much more serious issue of whether the resource allocation makes

sense. This is just not the time to make that decision and we ought to do that in June. So why don't you just update us and we ought to then have what is a serious discussion in June?

MR. ASHBY: Okay, why don't we flip over to the last overhead. Actually, if you flip to the second to the last one for just a moment and I'll be brief. You can skip down to the third bullet. I did want to point out here that we have discussed also and will also take up in the June retreat, the possibility of analyzing overall Medicare per capita cost again as input into discussing the most appropriate national and local blends. So I would add that these data will be helpful in that context as well.

Ideally, you would want to have an all-inclusive measure of your per capita cost, and this project will allow us to fill in the missing gaps and get us an all-inclusive measure. So it will serve that dual purpose at any rate.

DR. KEMPER: So a side benefit, which may be a very important side benefit, we'll get a sense of how far out of line the fee-for-service and the Medicare+Choice payments are by county.

MR. ASHBY: Right, exactly. Or to put it another

way, if we're trying to measure how much variation there really is in per capita spending, you can't really do that accurately unless your measure is really capturing all of your spending, which at the moment it's not. So that will be some benefit to keep in mind.

A quick note on the last page in terms of progress. This is indeed, we have to acknowledge, a complex process and part of that is because VA/DOD, and HCFA are all involved in it along with us. I'm sure everybody appreciates it's not easy to get all four of those agencies on the same page here. But in fact, all four agencies have expressed an interest in doing the project and are really rather enthused about it.

We have assigned roles and an agreement to split the cost and everything is pretty much in order except for the fact that we have been snagged on the Privacy Act because once you start matching databases across agencies it does bring in Privacy Act concerns. Actually, we have cleared that hurdle with both HCFA and DOD and we are in the process of resolving it with VA. In fact we just heard in the last 24 hours that we may be reaching a break-through point there.

So actually we may be at a point now that we can start the process. So we'll have to ask the question whether we want to go ahead and start the process to improve our chances of having data to look at for our next March report cycle. In fact it looks like at this point we may very well be able to do that. But if we didn't start until late summer or something, the chances of that would go way down.

DR. WILENSKY: My presumption, we will make this decision in the next five weeks in terms of -- I just think it makes sense to have it within the broader context of where our priorities need to be.

DR. ROWE: I have one concern about gaming that I'd just mention to you. I don't know if you can get data on it, but going forward you should be aware of it. It seems to me that a lot of the VA hospitals, for good reason, were built across the street from academic medical centers. Of the 172 VAs, I bet there's 40 or 50 across the street or very close to academic medical centers. Many of them are connected by bridges or tunnels, and that's very, very good for everybody I think.

If an academic medical center had a

Medicare+Choice contract on a capitated basis and had a bunch of beneficiaries that were included in that and the first question they asked them as they walked in, were you ever in the war, and if so, why don't you get your heart surgery across -- you know, we'll put you on this bridge over -- they do heart surgery over here, too.

MR. MacBAIN: Same surgeon.

DR. ROWE: The same doctor is going to do it, same residents, et cetera. I don't know that that would ever happen or has happened. I just thought of it as I'm sitting here looking at it, but I think that there might be a potential there.

MR. ASHBY: But you have to keep in mind there's the potential for that now.

DR. ROWE: That's my point. I understand that. It's implicit in this whole analysis. We were more concerned about financial fairness, but I think we should just look specifically -- that example might be a specific example of something you could track.

DR. WILENSKY: Thank you. We'll continue this in June.

Kevin and David?

MR. GLASS: Good afternoon. This is a brief update on a recommendation that was made that HCFA release a quick estimate of the update at the end of March as opposed to November so people would have a chance to comment on it. So we wanted to see whether it was feasible to do that with the information that's available at the end of March and we, therefore, have constructed all of this using available HCFA numbers.

Again, this is the update adjustment factor for the physician payment. What we've done is we've taken HCFA data and some up with an SGR for this year, and then we have taken a range of quarterly expenditures. The first column there it's $12 billion a quarter up to $12.5 billion a quarter, which represents probably the range of interest.

By the way, those are expenditures in the sense of the incurred, not the cash outlays. I remember that came up yesterday. So this is incurred. So it will probably show less of the bouncing around than you would if you were looking at cash numbers.

The updated adjustment factor is calculated using the current update adjustment formula, and then the conversion factor update, which is what's actually going to

be used to multiply the dollar number by, the conversion factor itself, is limited by the fact that you can only go 3 percent above the MEI, the Medicare index.

So you can see that if you have a $12 billion quarterly expenditure for the last two quarters -- and this would be the last quarter of 1998 and the first quarter of 1999 -- that you'll end up with an update adjustment factor of 1.06, which ends up with a conversion factor update of 1.053, or 5.3 percent, which is MEI plus 3 percent.

Higher actual spending yields a lower update because what you're doing is you're looking at the difference between your allowed spending and your actual spending.

Another recommendation you made is that as time progresses you go back and look at the SGRs you estimated earlier and update them for more recent information. Now if you do that in this case, the SGRs for historical go up and you can see that your update adjustment factor is going up 10 percent, 12 percent, 14 percent. Again, this means that the conversion factor update will be 1.053, or again, 3 percent plus the MEI.

So basically your higher SGRs yields a higher update factor because your allowed expenditure goes up if your SGR goes up. So that's the sensitivity there.

Now CBO estimates result in even higher SGRs, which would give you even higher update adjustment factors. That leads us to believe that an MEI plus 3 percent is a likely conversion factor update because over almost any of these scenarios that seems to be the most obvious.

This slide simply says, here's some of the updated SGR estimates for 1998, 1999, and 2000. What was announced in the Federal Register for 1998 was 1.5 percent. I think using the new HCFA data -- and we've moved it to a calendar year for a year I'll get into in a second -- it's 3.1 percent. And CBO looks like it would be even 3.3 percent.

So you can see that if you go back and update the original estimates -- 1999 was actually a negative. But if you go back and update those with current data it's going to really drive your update factor up.

Why is that? Well, the new -- relative to the announced -- there's a larger increase in real GDP per capita than was expected and I think the economy has done better than expected. So that's understandable.

Then there was a smaller shift in enrollment to managed care. Because there are four components in the calculation of the SGR. There's the fees, which is MEI and lab fees. Then there's the real GDP per capita, there's the enrollment in fee-for-service Part B, and then there's as a law and regulatory component.

But there's a smaller shift in enrollment to managed care which means the change in enrollment in the Medicare fee-for-service was not what was anticipated. So that accounts for most of the swing between the first column there and the second column.

Then the CBO data relative to HCFA, again there's a smaller increase in real GDP per capita in the CBO numbers and a smaller shift in enrollment to managed care. It's that enrollment in managed care that seems to be swinging the numbers around.

DR. CURRERI: I really appreciated this memo. I think it's very interesting. Does it suggest to you, or is it too early, do we have to look at a number of years, that the plus 3 percent limitation is too low? Because the negative is minus 7 percent, isn't it, the limit?

MR. GLASS: I don't think that we should get too

attached to the numbers because I think the whole update factor mechanism, the whole formula should be reevaluated. Because the current formula is going to force either high numbers or low numbers, and it's because it over-corrects. It's like a thermostat that you had that was set to the minute the temperature went below what you wanted it, the heat kicked on and you didn't turn the heat off until you reached the temperature you wanted. And then the heat keeps rising beyond that, so you've over-corrected.

This is even worse because it's kind of putting an air conditioner in there too, and as soon as it gets too high you're going to turn the air conditioner on and go way down the other way. So the oscillation is too great in the current one.

DR. CURRERI: So what would be your suggestion to correct for that oscillation?

MR. GLASS: We're working on fixing the formula. HCFA is working on it and I think between the two of us we'll come up with something that will work. You want to dampen the oscillations. This is tending to actually amplify the oscillations.

DR. LEWERS: Obviously it's nice to see something

go up for a change. But I guess my pessimism or my paranoia needs to come out, because it was just a month or so ago we were looking at these numbers headed south and we were talking about all sorts of numbers, and assumptions that were wrong. And we've made a number of suggestions for the SGR, which I think we need to stand by currently I guess. I find it interesting that you and HCFA are working on the formula which -- it will be very interesting to see where you go with that.

This whole picture that -- any formula we have, as I understand it, is going to have to be based on assumptions. For instance, on page 2 you talk about a 17 percent enrollment assumption. Yet we haven't gotten anywhere near that. They're actually dropping as time goes along, and with the plans pulling that has changed. Yet this is the number we're using here. What happens if suddenly next month we begin to say, we're not going to go 17 percent, we're going to go 10 percent?

Then the other factor is, as Kevin and I were talking about this earlier, we're talking about numbers that we really can't explain at this point as to why have the cost, the base number, why has that stayed down? Why is it

down? Do we have any idea why those numbers --

I guess I'm obviously very happy this is where we're headed, but I'm afraid next month we're going to come back in and oscillate the other way. So do you have any idea on these numbers, these assumptions? Are we going to have some way of controlling those? Does HCFA have some box up there that they push and it comes out with a different assumption each month?

MR. GLASS: You can see how HCFA and CBO in fact have differed on this.

DR. LEWERS: I know. That's what concerns me. When we had the '98, ended up in the '99 numbers and they said, oh, we made some errors in the assumptions. But yet we're trying to go back to Congress to get that corrected, because we talked about how these are changing.

DR. NEWHOUSE: No, you're not going back to Congress.

DR. LEWERS: I guess I'm very concerned on what --

DR. NEWHOUSE: That's why you're going up 3 percent. You don't have to go back to Congress. You're going up 3 percent because of those errors.

DR. LEWERS: No, I'm talking about to gain some of

the losses that occurred because of wrong assumptions.

DR. NEWHOUSE: But that's why you're going up 3 percent.

DR. CURRERI: 5 percent.

DR. LEWERS: I'm not sure that's right.

DR. NEWHOUSE: You're getting it deferred. It's playing out because of the 3 percent limit. There is this cumulative error correction built into here.

DR. LEWERS: I hope not. I'm just concerned that suddenly we're seeing numbers that have changed so dramatically. I'm afraid it's going to go right back the next time.

MR. GLASS: One of the reasons they're changing dramatically is because the update formula is over-correcting. I think that's the problem.

DR. CURRERI: But I don't understand -- I never did understand the asymmetry of the minus seven to plus three. It seemed to me that should have been symmetrical.

DR. LEWERS: We argued that at the time and lost.

DR. CURRERI: I know that.

MR. MacBAIN: It's symmetrical around minus two.

[Laughter.]

DR. CURRERI: It suggests to me that it should be symmetrical at plus five, minus five.

DR. ROWE: As I understand this, the greatest reason for your fears to be considered unfounded about our coming back next month and it being in the other direction is that we don't have a meeting next month.

[Laughter.]

DR. NEWHOUSE: But we set it at one point in time for the next year, then we don't revise it until the next year.

DR. ROWE: I think it's the volatility of the Medicare -- the fact that each of these two bullets has enrollment in managed care as one of the major drivers of the change and we have seen that to be somewhat unpredictable, which is giving this thing the volatility.

DR. WILENSKY: And also the fact that there's no an over-correction.

DR. NEWHOUSE: I think it's the over-correction that leads to try to have it symmetrical around zero.

DR. ROWE: They won't correct the data.

DR. NEWHOUSE: Or else fix the over-correction thing somehow. I don't see how to do that.

MR. HAYES: There's two possible explanations on the asymmetry issue. The truth is that the bottom --

DR. LEWERS: Be careful, Kevin.

MR. HAYES: Is that the MEI minus seven limit was established based on requirements for budget savings at the time that the BBA was passed.

The other way to look at it, to put the best possible light on the situation would be to say that -- let me see if I can get this straight. If you assume that the MEI is generally going to be around 2 percent, we put an upper limit on the conversion factor update of MEI plus, which gives you up to about five. And a lower limit of MEI minus seven would put you at minus five. So what you've done is you've established a --

DR. NEWHOUSE: It's kind of like moving the shell under the pea.

[Laughter.]

MR. HAYES: I understand that.

DR. WILENSKY: Why don't we just stop with the first explanation?

DR. LEWERS: We'll take the five.

MS. ROSENBLATT: I have an off-the-wall comment on

this. I was trying to get some education from Judy and Hugh earlier this morning because I'm still not totally up to speed on some of these provider payment updates. But it's very hard for me to understand the impact you're talking about, the volatility of the shifting enrollment to managed care because I think more like, in the discussion of the VA/DOD where you had the numerator and the denominator and the arrows.

It seems to me like you should be having your spending correspond with the people that are doing that spending, and there shouldn't just be this enrollment factor. Is that what it's really --

DR. NEWHOUSE: That's the intent. That's the intent of the adjustment.

MS. ROSENBLATT: But is it doing what is intended? Is there really a match-up between the spending on the particular people and -- I guess I'm asking, is there --

DR. NEWHOUSE: This gets back to maybe the demographic correction in the SGR that we were talking about a month ago, if that's what you mean by the particular people.

DR. KEMPER: Isn't the reason that this deals with

the aggregate expenditures rather than the average expenditures? The DOD was the average expenditures but we're talking about an aggregate.

DR. NEWHOUSE: This just says this is the size of the total pot for fee-for-service Medicare. So to do that you need to know how many people are in fee-for-service Medicare, and you have to guess at that.

DR. ROWE: Are there more than we expected because enrollment --

DR. NEWHOUSE: There are more than we expected so that cap was more binding than we anticipated it would be. So now we're going to make up for it by --

MS. ROSENBLATT: But are you capturing the fact that the people who leave might have different demographic characteristics?

DR. NEWHOUSE: No, that's last month's discussion on the demographic adjuster in the SGR.

DR. WILENSKY: That's right, and we don't do that.

DR. NEWHOUSE: And we should.

DR. LEWERS: It's very nice to know that an actuary doesn't understand it either.

DR. WILENSKY: Thank you, Kevin and David.

We can go to the last session unless, Peter, you'd like to -- are there some issues you'd like to raise on this?

DR. KEMPER: I just wanted to know whether the outside groups include health plans. I can talk to them...

DR. WILENSKY: Tom?

MR. KORNFIELD: I'm going to be presenting preliminary findings from the Medicare+Choice monitoring system. This is a system that we talked about in October and we've been working on developing the system and now we have some preliminary data to show you. The data is all at the county level. We haven't added the plan variables. We're going to add the plan variables. We haven't been able to do that just yet just because of some of the hold-ups in getting some of the data. But that's going to be the next step.

This basically gives a summary of what we found related to the Medicare+Choice plan pull-outs, both in terms of the pull-outs as contracts that did not renew altogether and contracts where they reduced the service areas.

First of all, it's unclear if payment was a dominant factor in the pull-outs. Now counties left with no

managed care plan options tended to have lower payment rates as compared to counties with at least one risk plan. But on the other hand, the counties that had a net loss in the number of risk plans but still had risk plans available or Medicare+Choice plans -- I'm going to use Medicare+Choice and risk plans kind of interchangeably just because, as far as I'm concerned, they're basically the same thing.

So what that sort of seems to imply is that on the one hand you had payment, which seemed maybe to be a factor related to the areas where there weren't any plan options. But on the other hand, a plan withdrawal where there were other plan options tended to happen in areas where you had higher payment rates. So it's not quite clear how payment necessarily means whether or not a plan was going to pull out.

But something that we did notice is that the counties left without managed care options tended to have very few Medicare managed care enrollees. The average county enrollment tended to be only about 674 in 1998. What that seems to imply is that these are areas that really didn't have a significant Medicare managed care presence and that may have been a significant factor in why some of the

plans left those areas.

The withdrawals also affected rural and urban counties. Perhaps not surprisingly, more of the rural counties were left without plans than urban counties. Again, that has something to do I think with the point that's right above it in terms of the enrollment and how these were fairly low Medicare managed care enrollment areas, and because of that they were also low Medicare managed care penetration areas.

Also we find that it's still the case that, as I think Peter was mentioning earlier, there are large portions of the U.S. without Medicare managed care plans. These tend to be rural areas, as you'll see on the map that I'm going to show you. There are large portions of the country -- actually if you look at the center of the country versus the coasts you'll find that the center of the country tends to be where we don't have a lot of managed care plans.

Enrollment in 1999 increased in most states. We find that in 38 states it increased, and in five states and the District of Columbia it decreased. So in most cases, in spite of the pull-outs, you still saw an increase in enrollment.

DR. WILENSKY: I wanted to ask you a question on the first slide. I don't know whether -- I'm not sure I can think of a way that you could capture this in your assessment.

But it troubled me that by focusing only on the payment rate issue it seemed to me you missed what was a big issue last fall, although hopefully it won't be a big issue this next year, which was that it was the inability to make an adjustment to the premium benefit combination that I think may have driven a lot of the plan withdrawals, and in some way make it much more -- if that's the case, make it more likely it would occur in places where there were multiple plans because it was in part a positioning of where people may have thought they had to position themselves early in the year, and then finding where they actually were in their own experience.

And that it was more a reflection of having to make a call in May about where you thought you wanted to be next January when you had a quarter of the year's experience, and also where you thought everybody else was going to be. And when it turned out -- you know, you might have been right about where you thought other people were

going to be, but you were wrong about where you thought you were in terms of your own experience. And by putting it only on payment, you really miss that whole line of what we heard.

Now you never know whether what you hear is really what is driving decisions, but it seemed to be raised by so many plans and backed up by their attempt to get HCFA to allow for some renegotiation. That I think you're sort of looking for an answer and then having to put hypotheses about why you're not finding that answer, when it was the hypothesis that it was primarily payment rates that really caused the withdrawal that troubles me.

MR. KORNFIELD: I guess the intent was not so much that the payment rates caused the withdrawal, but the intent was to try to show that it's a mixed picture. I think you've brought up a lot of the reasons why what happened last year was a transition year. I think clearly, if we're going to write this up in a more detailed analysis, I would certainly bring up a lot of those points that you just raised.

On the other hand, I just wanted to point out some of the trends that we've seen in terms of what actually

happened now. I mean, I agree that there were things that happened, that plans wanted to make changes. I think what we would need to know is what happened, those plans that wanted to make changes, what happened with their plan and what's going to happen next year. So that's why it's really important to kind of keep an eye on this and see what's going to happen in the future.

But I agree with you certainly, that there were a lot of factors that accounted for what happened last year.

DR. NEWHOUSE: I disagree with the inference that you're trying to draw about it being a mixed picture. I don't think the fact that counties that had a net loss, had average higher payment rates, entitles you to any inference. If you say that there's a probability of any single plan withdrawing that is related to the payment rate in the county, then the counties with higher payment rates have more plans.

So because of that fact, they're going to have a higher probability of a plan withdrawing. That is what you're finding, but it's still consistent with the payment rate being related to withdrawal.

MR. KORNFIELD: I agree with that. I think the

ultimate goal -- that's why I said unclear.

DR. NEWHOUSE: No, it's not unclear.

MR. KORNFIELD: Why is it not unclear?

DR. NEWHOUSE: You're not entitled -- there's nothing in these data that suggest that withdrawal is not related to payment rate.

MR. KORNFIELD: But there's nothing that suggests the other side either.

DR. NEWHOUSE: Yes, there is. There's your first fact. counties with no managed care option had lower payment rate.

MR. KORNFIELD: They also have low enrollment rate, so I think you'd really have to control for that if you were going to say it was one versus the other.

DR. CURRERI: That's true.

MR. KORNFIELD: In an ideal sense you'd want to do something where you were kind of predicting the probability of a plan being in an area and you'd want to look and see all these different factors and see how much they account for. I see what you're saying, though, in terms of you can't say it's one versus the other.

But I think ultimately speaking, my feeling is you

can't really say it's payment or it's not payment either way, because there are all these other factors that are kind of in it, and I think you'd want to measure those factors in some empirical way if you could, like with a Logent model or something like that, before you really could say it was one versus the other.

DR. NEWHOUSE: Maybe I'm not getting it across, but you and I can discuss this later.

MS. ROSENBLATT: I agree with the comments made by both Gail and Joe. I think there is tremendous danger here in coming to erroneous conclusions. I think that you're trying to match up the plans withdrawal with what I'm going to call the raw number of the payment rate. And the average of those over many areas, some of which are high and some of which are low.

So number one, I think that the data may be getting totally distorted by the averages because of the wide disparity. And number two, I'm not sure that the absolute rate of payment has anything to do with whether a plan is going to withdraw or not.

So I have two suggestions that I came up with about midnight last night by just really looking at this

data, in terms of additional analysis.

To pick up on what Gail said, I believe that there may be a correlation between the plans withdrawing and the penetration in particular county. So that the more managed care plans there are -- maybe that was what Joe was saying, is well, the more managed care plans there are -- I'm going to go actuary here for a minute.

The plans have been getting, it's alleged, positive selection. As the penetration increases they no longer have the ability to pull in the healthiest members of the population, so that their trend from year to year, due to an increasing age factor, because they're not pulling in as many new enrollees, they're going to suffer big trend from year to year.

If the payment trend --

DR. ROWE: To partially compensate for the advantages they had earlier.

MS. ROSENBLATT: Let's say they spent all that money. Let's just look at it on a roll forward basis.

So if the trend is this high and the payment only increases this much, there's going to be a problem. [Indicating.]

So it's more the percentage change in the rates from one year to the next, combined perhaps with that penetration factor, that may be the problem. It would be interesting to me to see the trend, which I know is going to be distorted by all the BBA impacts. But to me, that's the factor there.

DR. ROWE: I think what's relevant to that is that the fact that there's no age effect and the proportion of individuals by different age groups who opted to go into -- to re-enroll in another managed care plan -- suggests that there is neither adverse nor is there selective improvement by the managed care. It's selected.

It suggests that the managed care plans didn't go in when one managed care pulled out and recruit the youngest Medicare beneficiaries who were in the previous plan that dropped out and recruit them into their plan. Because the data show there's no effect of age.

Did you see that table?

DR. WILENSKY: That would have been a pretty complicated move to have pulled off for this period, but there certainly isn't any indication of that.

MS. ROSENBLATT: That's a pretty short period of

time.

DR. WILENSKY: But now that you've mentioned it, maybe we can get some interest.

DR. NEWHOUSE: Age is in the formula. There's no advantage to pulling by age. It's in the formula.

MR. MacBAIN: If the dependent variable here is ultimately a decision on the part of a plan to change, to change their marketing strategy to pull out of a place where they previously decided to go in, so it seemed to me that the independent variables ought to be changes, that we would want to say what change in the independent variables that caused this change in the plan decision making?

Now, for this time period my sense is that the base rates in most counties changed 2 percent, so the rate itself is not an issue.

MR. KORNFIELD: There's also the expectation of future rates, too. That's something that we haven't really talked about but it's something that -- I mean, that's a more ambitious thing that I mentioned. It's certainly not something that we're going to do.

MR. MacBAIN: Looking to the future, particularly over the next five years, you've got the blend between the

county and the national rate changing every year, the national rate changing based on national trends every year, the county rate changing based on the phase-in of risk adjustment factors for county-specific.

MR. KORNFIELD: Whether or not the blend is actually funded.

MR. MacBAIN: Each county has the opportunity to change a great deal from year to year, up or down or who knows. And it seems to me that that may turn out to be a very significant independent variable in predicting whether a plan pulls out of a given county.

DR. CURRERI: If you look back at the presentation Kevin gave just before, it's obvious that the expectations of penetration have not been met in the Medicare system. And I think that's a variable. In other words, we see, in getting the sustainable growth rate, that that factor is the most important factor in the formula.

It seems to me that failure to meet expectations in terms of enrollment --

MR. KORNFIELD: It may very well be, you know, the more I think about the payment question, the more I think that that is an erroneous statement because it's true that

it's sort of hard to know.

But I think there are some stories that I think we can pull from this. This is where the commission can really help, in terms of saying this is what we'd really like to point out in terms of what's happening, like what you're saying, Bill, in terms of the changes, the fact that there haven't been these big changes in enrollment.

The table that I gave around, that kind of showed what happened to beneficiaries, where they went.

This map, I think one of the things it really shows you is the fact that you see there's still large portions of the country that don't have any Medicare managed care plans. This has been true for -- if I took a map from a PPRC report from a few years ago, you'd probably see a similar type of finding.

What's also shown there are those red areas, and I have to apologize to the audience because you do not have a color slide.

The red areas are the areas that were left without managed care plans. As you can see, they tend to be scattered throughout the country. There's some in California. Utah was left without any Medicare managed care

plans. Northern Washington, some counties in New York, two of the three counties in Delaware.

Pennsylvania got a lot of new plans. I think the maximum number of new plans in any areas was two.

DR. ROWE: This one here suggests that Pennsylvania lost plans.

MR. KORNFIELD: No, Pennsylvania gained plans.

DR. CURRERI: But if you look at this map, the red areas are primarily rural areas in each state.

MR. KORNFIELD: That's right.

DR. CURRERI: That again goes to failed expectations of enrollment because there just aren't enough people to enroll there.

DR. WILENSKY: But those were no plans, isn't that? That wasn't just withdrawal?

MR. KORNFIELD: Yes, those are now zero plans in '99 but they had a plan in '98.

DR. WILENSKY: But what it may also have been, it made a bigger difference in these areas. It may well be that this was shallow penetration, not very firmly rooted, where there was a lot more activity where, in fact I think from your findings, where there were other plans and remain

other plans. It suggests that there may well be these two factors going on.

One that the plans misjudged where they wanted to be and they weren't allowed to switch and that some of the plans that had gone into areas that they had not previously been in or there wasn't a lot of managed care penetration when they had what was a hard year or what they anticipated would become a difficult year next year, withdrew.

DR. NEWHOUSE: If two plans merged, does that county as a lost plan?

MR. KORNFIELD: In this analysis, actually I don't think we accounted for merged plans. We've come up with a table that would account for that. So I think in this case if two plans merged, probably it does count as a lost plan but I'm not sure that it should.

MS. ROSENBLATT: Janet pointed out a couple of problems, too. I'm not familiar with this, so I'm just passing on what Janet said. She said that there may be a software problem and she thinks it's HCFA's problem. But she knows her plan pulled out of Arizona.

MR. KORNFIELD: Do you see those yellow areas? Those are areas where a plan pulled out, but there was still

another plan that either came in or was --

MS. ROSENBLATT: She was pointing at the green area, where there was a problem.

MR. KORNFIELD: Where there was no change?

MS. ROSENBLATT: Yes.

MR. KORNFIELD: I can check that. I'd have to know the county but it's certainly possible that she pulled out and somebody else went in there.

MS. ROSENBLATT: And then the other problem she mentioned is that you can withdraw from particular zip codes without withdrawing from the entire county. So that there was --

MR. KORNFIELD: Right. What we did is the way that this database is set up, and that's a really good point. The way that we set it up and again this map, there's a minimum number of plans in county and there's a maximum number of plans in county. That's kind of how we set it up.

So what you're talking about is let's say you pulled out of some zip codes and not other zip codes. So you still serve part of the county but not the whole county. So there's kind of the sense of if you really want to do it

at a detailed level.

And I think that probably tends to be more of a problem in -- I'd have to check this, but my guess is that in places like California, we're not sure what other areas really have this zip code where plans are really being -- sort of at the zip code level versus at the county level.

So that's where I think if we were going to do more detailed analysis, it probably should really target those areas and then you can really get it -- because we have service areas by zip code, so it's just a question of building that data.

DR. ROWE: Am I interpreting this correctly, that the peninsula in which San Francisco and Palo Alto and all that is based, there's no Medicare --

MR. KORNFIELD: No, it's lower down on the map. Actually, there's a lot of California that's pretty rural. The whole northern part is rural.

DR. NEWHOUSE: It's south of Monterey.

MR. KORNFIELD: It takes 10 hours to get from Portland, Oregon, if you're driving, to San Francisco.

DR. ROWE: But it's red.

DR. NEWHOUSE: But that red is the part that's

Monterey Bay and south.

DR. CURRERI: It's very rural out there.

MR. KORNFIELD: That little green thing in the center, that's probably San Francisco.

DR. NEWHOUSE: No, the little green thing in the center, I think, is Santa Cruz County. We should probably stop.

DR. WILENSKY: We can have that labeled.

DR. ROWE: So the white thing is not San Francisco Bay? A county without a plan.

MR. KORNFIELD: No, the white thing is just redwood forest, I think.

I just wanted to say what happened with the withdraws in terms of the beneficiary impact. This is from looking at the group health plan master file. This actually does, Joe, take into account mergers. Withdrawals and service area reductions affected about 429,000 beneficiaries.

I think this is kind of important. Among the enrollees that could choose another HMO, two-thirds of them joined another HMO, whereas one-third went back to traditional Medicare. So the pull-outs, while they had an

effect on about 430,000 people, most of them in fact decided to stay in an HMO despite of the pull-out.

About 16 percent of the affected beneficiaries could not choose another Medicare HMO, and this goes to what we were talking about before, that these were low penetration areas and low Medicare enrollment areas.

That's it.

DR. WILENSKY: Thank you. I assume we will continue this monitoring.

Any public comments on this or earlier sessions?

AUDIENCE SPEAKER: I have one quick comment on the VA/DOD adjustment. The green county phenomenon that was shown with the $404, you'll find something if you look at major military installations, you'll find the wage indexes surrounding those areas are depressed all over the place. I just want to point that out, that there's another factor in there that needs to be considered.

DR. WILENSKY: Yes, thank you. That's a very good point.

We will have our next public meeting Wednesday, June 16th, in the morning in the Cannon caucus room. We will summarize and discuss the results of our work plans for

the next year as of that time, and also any additional discussions that may have gone on with regard to graduate medical education.

Thank you all.

[Whereupon, at 2:11 p.m., the meeting was adjourned.]